

**NURSES' PERCEPTIONS OF BOUNDARIES WITH SERVICE USERS IN
ACUTE MENTAL HEALTH INPATIENT SETTINGS: A GROUNDED THEORY
STUDY**

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RESEARCH PROJECT PORTFOLIO ABSTRACT

This thesis explores mental health nurses' perceptions of boundaries with service users in acute mental health inpatient settings. This is against a backdrop of notions of recovery implying a relaxation of boundaries, but with an increasing dominance of concerns with risk. This thesis is divided into two sections, with the first part containing a journal paper that is ready for submission. The second section, an extended paper, is required to be read alongside the journal paper. The extended paper contains more detailed information that could not be presented within the journal paper.

The journal paper concentrates on the main literature about recovery approaches and service users' views about the relaxation of boundaries as part of their recovery, alongside barriers to the relaxation of boundaries within the acute mental health inpatient setting. It highlights the gap in the current literature which the thesis aims to address. In order to build a theory about what mental health nurses within the acute psychiatric setting perceive as boundaries with service users, a grounded theory methodology was used. This was used to analyse transcripts of semi structured interviews carried out with the mental health nurses. Three descriptive categories were constructed from the analysis relating to how mental health nurses perceive boundaries: the socially constructed nature of boundaries; the perceived need for boundaries; and enacting boundaries. Theoretical categories were constructed to embed the analysis in the broader cultural setting.

The extended paper sets the research against a broader background about recovery approaches and the dominance of the discourse about risk aversion. It specifically explores boundaries in relation to recovery principles and

risk, as well as factors that may hinder the relaxation of boundaries, such as stigma and othering. It offers additional information about the methodology and analyses of the data. It has a detailed reflection and memos about the research process. The results section concentrates on factors that impact on mental health nurses' perceptions of boundaries. The theoretical categories are presented which aim to account for the data gained, rather than to just describe it.

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STATEMENT OF CONTRIBUTION

The author, Amy Richardson, contributed to project design, application for ethical approval from both the university and the relevant research and development department, and performed the literature search. The author also recruited the participants, collected the data and performed the analyses and has written all parts of this thesis.

The research supervisor, Anna Tickle, contributed to the project design and offered advice and guidance on the analyses and final write-up of the thesis. The field supervisor, Lisa Ball helped in the process off recruitment.

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SYSTEMATIC LITERATURE REVIEW

Service user experiences of acute psychiatric inpatient units: A meta-ethnography *

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ACCESSIBLE SUMMARY

- There is a growing dissatisfaction with care on acute psychiatric inpatient units.
- Six studies were identified that specifically explore service user experiences of acute psychiatric units.
- By examining these studies it was found that experiences were influenced by relationships, sense of safety, and treatment on acute psychiatric units.
- It is suggested that these three aspects are linked by a person's sense of powerlessness.

ABSTRACT

The purpose of this review was to systematically identify and synthesise qualitative literature relating to service user experiences of acute psychiatric inpatient units, as well as appraising the quality of research in this area. The selected papers were analysed using a meta-ethnographic approach and the results are reported with clinical and service level implications, as well as ideas for further research. Three third order constructs were developed that influence service user experiences: the importance of relationships, safety, and treatment.

It is suggested that each of these constructs are linked by the theme of powerlessness that the individual may experience in relation to being able to influence interactions, treatments and the acute psychiatric environment. The implications of this suggests that service level changes are needed to provide an environment that is less restrictive to service users, and that perhaps service users can be instrumental themselves in making these changes. Further research is needed in the area with a focus on improved quality of the qualitative research.

Key words: acute psychiatric inpatient, experience*, qualitative, service user,

* The author intends to submit this article to the Journal of Psychiatric and Mental Health Nursing

INTRODUCTION

The Sainsbury Centre of Mental Health (SCMH, 2002) describes acute inpatient psychiatric care as being a core component of mental health services. Indeed, they report that 25% of the total health and social care budget for mental health, which equates to £800 million pounds per year, is spent on acute inpatient care (SCMH, 2002). However, despite the importance of this area of mental health care, there is a limited evidence base on service user experiences of acute inpatient units that does not support the use of inpatient care as a therapeutic intervention.

In 1998, the SCMh completed a study of 215 service users' satisfaction of acute inpatient units. It was found that the underlying needs of service users were not being met, with staff and service users disagreeing about the most pressing needs. Further, service users received little information about their illness and possible treatments, and reported being bored with no social or recreational activity. Ten years later service users are still reporting inpatient units to be inherently unsafe and as failing to meet their needs (Rose, Fleischman & Wykes, 2008). Short (2007) reported his own experiences of being an inpatient and describes not being asked about how he was feeling, a lack of privacy and often feeling invaded. In ward rounds he reported staff giving descriptions of him that were in conflict to his own experiences. His experiences with staff seemed inconsistent, with different staff seeming to have their own ideologies about acute inpatient care.

There have been several sets of guidelines published, by for instance the Department of Health (DOH), the SCMh and The Royal College of Psychiatrists (RCPsych), to help services improve the conditions on acute inpatient units. In

2002 the DOH added a supplement to the Mental Health Policy Implementation outlining that service users should be involved in structuring and implementing therapeutic regimes. More recently the Accreditation for Inpatient Mental Health Services (AIMS) standards (RCPsych, 2010) set out standards to help acute inpatient units to show compliance with the DOH '*Standards for better health*' (DOH, 2004). They outline that the service user's perspective should be taken into account when creating care and management plans, that there should be an informed discussion about the benefits and side effects of medication, and there should be access to a psychological therapist for four hours per week (RCPsych, 2010).

Despite these guidelines, there is a clear discrepancy between the aims and purpose of acute inpatient units and the actual experiences of service users. Although there has been some research into the experiences of service users, this remains an under-researched area. However, it is important to gain insight into the experiences of service users who have been inpatients as a means to improving psychiatric hospital services (Walsh & Boyle, 2009). Indeed, in 2004 the DOH emphasised a needs based approach to tackling mental health care in their publication '*Standards for better health*' (DOH, 2004). However, it is difficult to see how a need based approach can be developed without investigating the experiences of those who use the services and how their needs could be best met.

Exploring experiences through qualitative research is important in developing mental health services as evidence based medicine can be removed from the experience of the person being treated (Faulkner & Thomas, 2002). Tait and Lester (2005) further that qualitative research can offer a unique

perspective of the 'expert patient' in identifying individual needs. Indeed, Rose et al., (2008), when investigating areas of research that service users thought would be important, found that research to help improve the inpatient ward environment, procedures and culture would be incredibly valuable. Therefore, there is a clear need to investigate service user experiences of being an inpatient on an acute psychiatric unit in order to begin improvements that are so desperately needed within this setting.

However, qualitative research to explore service user experiences may risk marginalisation from clinicians and policy makers, as this type of research can seem isolationist, with little influence over strategy or policy (Doyle, 2003). However, meta-syntheses may offer a deeper analysis, allowing new insights to emerge. Sandelowski, Docherty and Emden (1997) further that meta-syntheses can uncover generative processes of phenomena that may not be glimpsed from individual studies.

One approach to meta-synthesis is meta-ethnography (Noblit & Hare, 1988). Using the findings of existing case studies, meta-ethnography uses strategies to construct new interpretations for the cases selected and aims to move towards reconceptualization (Noblit & Hare, 1988). Meta-ethnography uses multiple empirical studies but the sample is purposive rather than exhaustive because the purpose is interpretive explanation and not prediction, as in meta-synthesis (Doyle, 2003).

Therefore, the aims of this meta-ethnography were to systematically find and appraise qualitative research, which sought to explore the experiences of service users who had spent time as an inpatient in an acute psychiatric unit. In addition, the aim was to synthesise the research findings in order to try and

explain what may impact on the service user experience. This may help to inform changes within the clinical setting that are clearly needed given the findings from studies presented above.

METHODS

This review was carried out in three stages: systematic searching of the literature, critical appraisal of the literature, and synthesis using a meta-ethnographic approach, as outlined by Noblit and Hare (1988).

Searching

A systematic search was carried out using five electronic databases: PsychINFO; MEDLINE; Cumulative Index of Nursing and Allied Health Literature (CINAHL); Academic Search Elite and Web of Science. These databases represent the disciplines of nursing, medicine and the social sciences, and were chosen to increase the comprehensiveness of the database search. For all databases, groups of terms were combined relating to the following parameters: terms relating to mental health, terms relating to service user experiences of an acute inpatient unit and terms relating to qualitative research. These were service user*, consumer, patient, experience*, perception, view, acute, mental health, psychiatric ward, unit, inpatient, qualitative, discourse analysis, grounded theory, thematic analysis, interpretive phenomenological analysis, phenomenological analysis, ethnography.

All searches included the limits of 'peer-reviewed' and 'adulthood', to include participants aged over 18 years. Reference lists of each article identified as relevant were hand searched to identify further research studies that maybe relevant.

Selection

The numbers of articles retrieved from the search are shown in figure 1, in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Liberati et al., 2009). Once duplicates had been removed, titles of remaining articles were assessed for their eligibility to be included in the meta-ethnography.

Studies were included in the meta-ethnography if they met the following criteria:

- used a qualitative methodology;
- were peer reviewed;
- included only participants over 18 years of age;
- were written in the English language;
- included first-person perspectives of experiences of being on an acute psychiatric inpatient unit.

Studies were excluded if they included a second person perspective about the experience of being an inpatient on an acute psychiatric unit (for instance, family, carers or mental health professionals). In addition they were excluded if they were published prior to the year 2000. This is in line with the DOH's National Service Framework guidelines for modernising mental health services (DOH, 1999)

All citations were checked for relevance by checking the titles initially. The abstracts of possible relevant articles were then examined and full text versions of those that appeared to meet the inclusion criteria were obtained. Following

examination of the full text articles, six were selected for inclusion in the meta-synthesis. The properties of these are shown in figure 1 below.

Figure 1.

The process of selection based on PRISMA statement (Liberati et al., 2009).

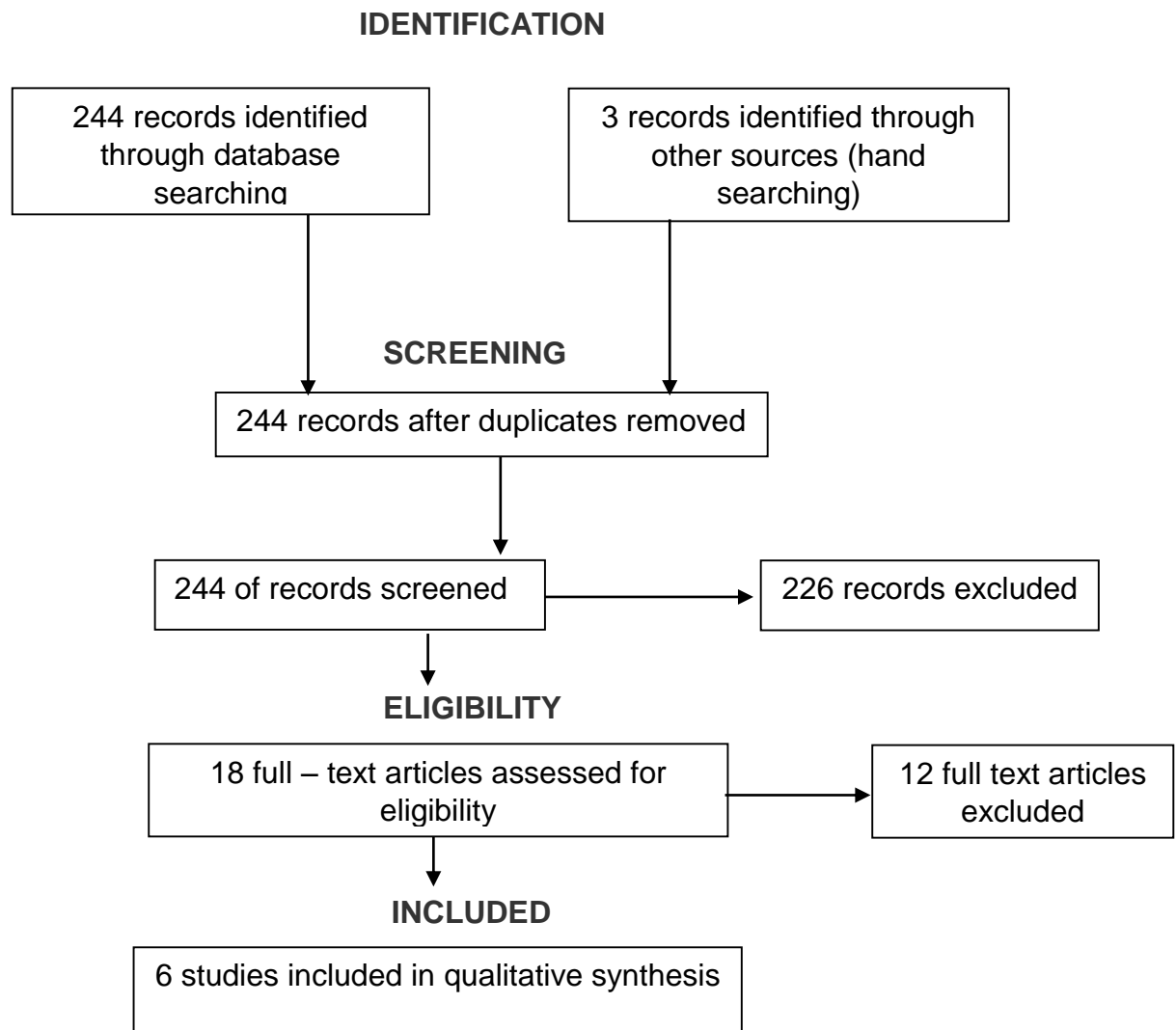


Table 1. Data extraction table showing the characteristics of the studies included in the synthesis

Study Code	Author (Year)	Country	Aims	Participant Gender and total N	Participant Age	Ethnicity	Data Collection	Method of Data Analysis
1	Jones <i>et al.</i> (2010)	United Kingdom	To explore the experiences of service users on acute inpatient psychiatric wards, with a particular focus on feelings of safety and security.	36 male 24 female 60	19 – 81 years	White = 40 Black/Black British = 11 Asian/Asian British – 6 Other ethnic groups - 3	Semi structured interviews	Thematic analysis
2	Secker & Harding (2002)	United Kingdom	To explore the inpatient experiences of a sample of African and African Caribbean people	16 male 10 female 26	18-24 years = 2 25-44 years = 18 45-53 years = 6	African-Caribbean = 18 African = 6 Unavailable = 2	Semi structured interviews	Staged content analysis
3	Johansson & Lundman (2002)	Sweden	To obtain a deeper understanding of experiences of being subjected to involuntary psychiatric care.	2 male 3 female 5	27-49 years	NS	A narrative method of conducting interviews	Phenomenological hermeneutic method
4	Walsh & Boyle (2009)	United Kingdom (Northern Ireland)	To explore psychiatric inpatients' strategies for coping with mental ill health and in what ways acute inpatient psychiatric hospital services are facilitative to the individual attempting recovery	Gender N/S 55	16-68 years	NS	Focus groups	Systematic content analysis
5	Gilbert, Rose & Slade (2008)	United Kingdom	To explore the experiences of admission to acute psychiatric hospital from the perspective of service users.	10 male 9 female 19	25-60 years = 16 60+ years = 3	13 = White British 1 = White European 3 = Black British 2 = Asian British	10 participants = focus group Nine participants = unstructured interviews	Thematic analysis
6	Stenhouse (2011)	United Kingdom (Scotland)	To gain insight into the experience of being a patient on an acute inpatient psychiatric ward, with a focus on the theme of 'help'.	6 male 7 female 13	18-65 years	NS	Unstructured interviews	Holistic analysis

Quality Appraisal

One of the aims of this review was to appraise the quality of the studies exploring service user experiences of being an inpatient on an acute psychiatric unit. This was carried out using the Critical Appraisal Skills Programme (CASP) pro forma. CASP was initially developed in 1993 to help those making health care decisions to be more systematic in their appraisal of scientific evidence. The programme has developed a number of appraisal tools to cover a range of different types of research and CASP is now used in disciplines outside of healthcare such as education, social services and information science.

The selected papers were initially subject to a full CASP assessment to appraise their quality, which involved appraising their quality initially on two screening questions to do with their aims and the appropriateness of qualitative methodology, and then eight more in depth dimensions. Despite a variation in quality, each article was included in the synthesis as it was thought they could contribute something of value to the synthesis.

The rationale for quality appraisal is that if qualitative research is to be used in evidence based practice then quality markers are needed to judge the quality of the research and it is crucial for the integrity of the qualitative method (Walsh & Downe, 2005). As yet, there is no one single method thought to be the most useful tool to appraise qualitative research, and as Cohen and Crabtree (2008) state, qualitative research is not a unified field.

Data Abstraction

The meta-ethnographic approach as outlined by Noblit and Hare (1988) was used, incorporating the seven phases that they suggest, as follows. The papers

were read and re-read several times to allow the synthesist to become familiar with the original texts and to construct summaries of their findings. Data from each study was extracted and was then compiled into first (participants' views and accounts), second (the original studies' authors' views and interpretations of participants' experiences) and third order constructs (views and interpretations of the synthesist) (Doyle, 2003). Emergent themes were recorded for each study in terms of first and second order themes and comparisons were made between each study using a matrix. Third order themes could then be identified as key themes that were emerging across the studies. Doyle (2003) has described this as 'an interpretation of the interpretations'. (p. 330). This method condensed information into meaningful themes. However there may be some overlap between the themes, although to exclude aspects of themes as a result of this may not allow an in depth examination of the data.

Once third order constructs had been developed, three forms of meta-ethnographic synthesis were carried out (Noblitt & Hare, 1988). They include reciprocal translation, in which similar themes across the individual studies are synthesised into one another. However, synthesising the key concepts from studies also attends to those concepts which seem to be conflictual, and can be integrated through refutational synthesis. The intent is to produce a line of argument synthesis which integrates these similarities and differences to generate third order constructs, thus creating new meaning and new perspectives of the subject being reviewed (Noblitt & Hare, 1988).

The quality appraisal of the six studies is discussed first. The synthesis of the results of the six studies will then be discussed.

RESULTS

This synthesis incorporated the findings from six papers, with 178 participants in total. 57% of participants were male, and 43% female (although this discounts study four, where gender was not specified). Participants ranged from 16 to 81 years of age. Three studies commented on the ethnicity of the participants (studies one, two and five). To collect the data, one study used a focus group (study four), and one used a focus group alongside semi-structured interviews (study five). The remaining four studies collected data through interviews. The methods of analysis varied amongst the studies. The characteristics of the studies along with their research aims are shown in table 1.

Quality Appraisal

One aim of this review was to note the quality of the current qualitative research which explores service user's experiences of being an inpatient on acute psychiatric wards. The results of the quality appraisal are shown in table 2.

All of the studies met the criteria for demonstrating the aims of their research clearly and for using qualitative methodology appropriately. All studies seemed to have appropriate research design, were explicit in how the data were collected, explained how participants were selected, and gave details of the form in which data was recorded. All studies presented their findings clearly, discussed evidence supporting and contradicting their arguments, the findings in relation to the original research question and the contributions of their findings in relation to existing knowledge and understanding.

However, in relation to the rest of the criteria, quality was variable. For example three studies failed to explain clearly why their participants were most

appropriate to provide the knowledge they sought (studies 1, 3 and 4), and some did not address the issue of why participants chose not to take part (studies 3, 4 and 5). Study 1 did not justify the setting for data collection or justify the methods of data collection and in addition, this study did not give any details regarding the semi-structured interviews carried out. In terms of the relationships between researcher and participants, the majority did not consider this when forming the research question and in relation to data collection, with the exception of studies 3 and 5. Four of the studies failed to report whether the researcher examined their own role during data analysis (studies 1, 2, 4 and 6).

Consideration of ethical issues also seemed to be lacking. Only two studies (studies 3 and 6) discussed in detail how they explained the research to participants and three studies did not discuss issues raised by the study, including the impact of the study on participants (studies 1, 2 and 5). Two studies did not comment on seeking ethical approval (studies 2 and 5).

Again, the quality of the studies in relation to analysis was variable. Studies 4 and 6 did not describe the process in detail, and these studies failed to explain how they derived their themes from the data, and did not explain how the data presented were selected from the sample of data. Study 4 did not present sufficient data in the form of participant quotes to support their findings, and did not take into account contradictory data, along with study 3. Studies 1, 2 and 4 did not discuss the credibility of their findings and four studies did not discuss new areas of research (studies 2, 3, 4 and 5) and only study 2 discussed how the research could be used in other ways, or transferred to other populations.

It should be acknowledged that some studies will have had word restrictions from the journal which may have meant that could not have addressed all of the criteria presented here. However, despite a few areas that studies consistently addressed, there are some areas that will need to be addressed when exploring the experiences of services users as inpatient on acute psychiatric wards. This includes in particular examining the researchers' and participants' relationship in the research, Ethical issues may also need to be considered more carefully, particularly in relation to the impact the research may have had on participants.

Table 2.

Quality appraisal of studies included in the synthesis utilising criteria outlined by the Critical Appraisal Skills Programme

Essential Criteria	Points to Consider	Study Code					
		1	2	3	4	5	6
Was there a clear statement of the aims of the research?	-What the goal of the research was -Why is it important -Its relevance	Yes	Yes	Yes	Yes	Yes	Yes
Is a qualitative methodology appropriate?	-If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants	Yes	Yes	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	-If the researcher has justified the research design (e. g. have they discussed how they decided which method to use)?	No	Yes	Yes	Yes	Yes	Yes

Was the recruitment strategy appropriate to the aims of the research?	-If the researcher has explained how the participants were selected	Yes	Yes	Yes	Yes	Yes	Yes
	-If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study	No	Yes	No	No	Yes	Yes
	-If there are any discussions around recruitment (e. g. why some people chose not to take part)	Yes	Yes	No	No	No	Yes
Were the data collected in a way that addressed the research issue?	-If the setting for data collection was justified	No	Yes	Yes	No	Yes	Yes
	-If it is clear how data were collected (e. g. focus group, semi-structured interview etc.)	Yes	Yes	Yes	Yes	Yes	Yes
	-If the researcher has justified the methods chosen	No	Yes	Yes	Yes	Yes	Yes
	-If the researcher has made the methods explicit (e. g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?	No	Yes	Yes	Yes	Yes	Yes
	-If the methods were modified during the study. If so, has the researcher explained how and why?	NC	NC	NC	NC	NC	NC
	-If the form of data is clear (e. g. tape recordings, video material, notes etc.)	Yes	Yes	Yes	Yes	Yes	Yes
	-If the researcher has discussed saturation of the data	No	No	No	No	No	No

Has the relationship between researcher and participants been adequately considered?	<p>-If the researcher critically examined their own role, potential bias and influence during:</p> <ul style="list-style-type: none"> • Formulation of the research questions • Data collection, including sample recruitment and choice of location <p>-How the researcher responded to events during the study and whether they considered the implications of any changes in the research design</p>	No	No	No	No	Yes	No
		No	No	Yes	No	Yes	No
		No	No	No	No	Yes	No
Have ethical issues been taken into consideration?	<p>-If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained</p> <p>-If the researcher has discussed issues raised by the study (e. g. issues around informed consent or confidentiality or how they handled the effects of the study on the participants during and after the study)</p> <p>-If approval has been sought from the ethics committee</p>	No	No	Yes	No	No	Yes
		No	No	Yes	Yes	No	Yes
		Yes	No	Yes	Yes	No	Yes

Was the data analysis sufficiently rigorous?	-If there is an in depth description of the analysis process	Yes	Yes	Yes	No	Yes	No
	-If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?	Yes	Not used	Not used	No	Yes	No
	-Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process	Yes	Yes	Yes	No	Yes	No
	-If sufficient data are presented to support the findings	Yes	Yes	Yes	No	Yes	Yes
	-To what extent contradictory data are taken into account	Yes	Yes	No	No	Yes	Yes
	-Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation	No	No	Yes	No	Yes	No
Is there a clear statement of findings?	-If the findings are explicit	Yes	Yes	Yes	Yes	Yes	Yes
	-If there is adequate discussion of the evidence both for and against the researcher's arguments	Yes	Yes	Yes	Yes	Yes	Yes
	-If the researcher has discussed the credibility of their findings (e. g. triangulation, respondent validation, more than one analyst)	No	No	Yes	No	Yes	Yes
	-If the findings are discussed in relation to the original research question	Yes	Yes	Yes	Yes	Yes	Yes

How valuable is the research?	-If the researcher discusses the contribution the study makes to existing knowledge or understanding e. g. do they consider the findings in relation to current practice or policy, or relevant research based literature?	Yes	Yes	Yes	Yes	Yes	Yes
	-If they identify new areas where research is necessary	Yes	No	No	No	No	Yes
	-If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used	No	Yes	No	No	No	No

NC = Not commented

Interpretation of findings

Key themes were highlighted throughout the meta-ethnography process, which centre around three third order constructs: importance of relationships, safety and treatments. Within these themes, there were also sub-themes. These are shown in table 3, which illustrated which themes were derived from which studies.

Table 3.
Third order constructs identified from the six studies

Themes Sub-themes	Study 1 Jones et al. (2010)	Study 2 Secker & Harding (2002)	Study 3 Johansson & Lundman (2002)	Study 4 Walsh & Boyle (2009)	Study 5 Gilbert, Rose & Slade (2008)	Study 6 Stenhouse (2011)
Importance of Relationships	*	*	*	*	*	*
Relationships with staff	*	*	*	*	*	*
Peer relationships	*		*	*	*	*
Safety	*	*			*	
Fear of other service users	*				*	
Racism	*	*				
Treatment		*	*	*	*	
Coercion		*	*	*	*	
Medication		*		*	*	
Choice		*	*	*		
Alternatives to Medication		*		*	*	

Importance of Relationships

One of the most evident themes within the studies was the importance of relationships for participants. This was a recurrent theme which all studies referred to and represents a reciprocal translation, as all studies referred to both positive and negative interactions with others. This third order construct was further divided into two sub-themes: relationships with staff and relationships with other service users.

All studies referred to positive aspects of relationships with staff. Several participants spoke of nurses who spent time listening, participating in social conversation and in leisure activities, and Walsh and Boyle (2009) suggest that such descriptions highlights the need for a therapeutic relationship built on trust, empathy and mutual respect. Such experiences with staff left participants feeling supported and cared for, that they had been taken seriously and had been given adequate time to be heard.

More often however, participants reported that nurses did not approach them to talk, and this could be interpreted as a lack of caring and disinterest (Stenhouse, 2011). This meant that participants tended to feel that they had to take responsibility for seeking help, but there were barriers to them being able to do this. (Gilbert, Rose & Slade, 2008; Johansson & Lundman, 2002; Stenhouse, 2011) These included nurses being too busy to talk and offer support, which participants found frustrating.

'...I was told if I want somebody to speak to I'd get somebody to speak to. I mean we're not talking about when there's an admission coming in, or when somebody's kicking off. I'm talking about when there's no' much doing and you'd

just like to talk to them, ken, just to try and explained what's happened.'
(Stenhouse, 2011, p. 77)

Staff's unavailability is therefore an obstacle to communicating and forging relationships, and not being able to communicate leaves people with sense of powerlessness about being able to influence circumstances (Gilbert, Rose & Slade, 2008).

Generally, there were few negative references about relationships between service users. Indeed, speaking to other service users helped to reduce feelings of isolation and the experience of speaking to others offered support and counselling (Stenhouse, 2011), and a sense of camaraderie, empathy, support and friendliness was described (Jones et al., 2010).

'I like them (the service users). I get on well with them. I find them very helpful. Talking problems through with other patients that you've had yourself, it's quite therapeutic' (Jones et al., 2010, p. 128).

Walsh and Boyle (2009) found that service users were more likely to speak to each other as they tended to be more available than staff, although when given the opportunity participants preferred to speak to staff about personal causes to their mental distress.

However, Stenhouse (2011) found that the formation of supportive relationships was dependent on who was on the ward and whether service users could relate to each other. The emotional needs of participants when on the ward resulted in the rapid formation of closeness within their relationships with peers.

Participants could be vulnerable to further emotional upset as taking on other's problems or when those they were close to were discharged or died.

Safety

This theme was found in three of the studies (Jones et al., 2010; Secker & Harding, 2002; Gilbert et al., 2008), and represents a refutational synthesis as some studies spoke of participants experiences of feeling unsafe, whereas others spoke of the feelings of safety being in an enclosed environment could bring. Two sub-themes were identified: fear of other service users and racism.

Many participants described feeling that other service users were a potential danger to them, perhaps because of the way others looked at them, or because of the bizarre and aggressive behaviour of others. Half reported witnessing or experiencing violence. Gilbert et al., (2008) suggested that a sense of fear depended on the nature of the interaction with other service users.

'There are patients who sort of either deliberately or through their illness are very aggressive (.) That's when I don't feel comfortable because you don't want to get involved in something which is going to cause you harm or, an argument breaking out, and then, you know, the tension building up' (Secker and Harding, 2002, p. 126).

Gilbert et al., (2008) also found that perhaps gender could play a role in fear associated with violence. Men and women felt vulnerable where there was a predominance of men, and there were reports of men being attacked by other men, and one woman reported being attacked on an all female ward.

Other things associated with safety included bullying especially in relation to cigarettes, alcohol, drugs or money and many felt they could be coerced by other patients to buy and smuggle drugs or alcohol onto the ward for them. Theft of personal possessions also contributed to a lack of safety (Jones et al., 2009).

However, Jones et al., (2009) found that two thirds of participants felt that could ask staff to help them if there was something frightening or dangerous happening on the ward. They felt reassured when staff were around and were confident that staff would intervene if there were arguments or conflict.

Gilbert, et al (2008) also found that there was a perception amongst service users that staff may also be fearful of service users. This fear was attributed to a lack of control by staff and included a fear of service users harming themselves and others. They suggested that this fear resulted in the use of coercive measures.

Experiences of racism contributed to feelings of a lack of safety on the wards, and racism towards ethnic minority patients was reported in two studies (Jones et al, 2010; Gilbert, Rose & Slade; Secker & Harding, 2002). In the study by Jones et al. (2010) many participants had either witnessed or had experienced racism including by staff. When clients attempted to complain about racist treatment, they found services unable to respond adequately.

'When people have been racially abused, I find that they don't know what to do about it...don't know what to achieve to say well they should ban the person, or if they do this, or do that' (Secker and Harding, 2002, p. 163).

Secker and Harding (2002) suggest that the capacity of inpatient services to meet client needs depended less on availability of staff with similar ethnic backgrounds, but more to appreciate the client's perspective and to work with them to find ways of addressing their problems. Indeed, it was not always overt racist behaviour that was reported, but a sense of not being understood as a result of racial and cultural differences.

There were some positive experiences reported related to safety. Johansson and Lundman (2002) found that there was a feeling that involuntary care was needed for the benefit of the patient and that in time hospital could be pleasant and satisfy needs.

'And then, that you maybe for your own safety and the safety of others have to be locked in on the ward...it is done for my own good' (Johansson & Lundman, 2002, p. 644).

Treatments

This theme was found in four of the studies (Secker & Harding, 2002; Johansson & Lundman, 2002; Walsh & Boyle, 2009; Gilbert et al., 2008), and again represents a refutational synthesis as all studies spoke of participants negative experiences of treatments, but some spoke of positive experiences. Four sub-themes were identified: coercion, choice in treatment, medication and alternatives to medication.

Four studies found issues around coercion. (Secker & Harding, 2002; Johansson & Lundman, 2002; Walsh & Boyle, 2009; Gilbert et al., 2008). This seems to be linked with receiving treatments that participants had no discussion

in, as it is likely they may have been coerced into the treatments.(Johansson & Lundman, 2002: Gilbert, Rose & Slade, 2008).

Johansson and Lundman (2002) found that participants reported experiences of being exposed to superior force and inhumane treatment, and participants felt that staff could cross the limits of integrity. Physical restraint was always accompanied by forcible medication, and in the study by Gilbert, Rose and Slade (2002), it was described as physical assault. As the following quote shows, there are experiences of unnecessary violence and of too many people being involved.

'...I become aggressive when they use violence, it's an encroachment when they don't say anything but just catch hold of you and drag to the bed and give you the injection with force and a lot of people are holding you. They didn't have to use violence...They didn't need a whole army from two wards' (Johansson and Lundman, 2002, p. 643).

There were threats of non-physical force for consequences of not obeying staff, which was seen as a form of perceived coercion. This was described as being hypnotised and brainwashed and reactions to perceived coercion were labelled as playing the game. This could result in service users being fearful of staff who could provide unpleasant medication and who could treat people coercively. This use of coercion was also associated with mistrust (Gilbert et al., 2008).

'I felt frightened of the doctors. They were putting me on drugs that had terrible reactions. I felt frightened' (Gilbert, Rose & Slade, 2008, p. 5).

It was felt that staff were not interested in what service users had to say, or how they felt about treatment. This was associated with a feeling of helplessness and insecurity, as well as a loss of control (Secker & Harding, 2002). Johansson and Lundman (2002) found that participants wished for more contact with staff, where they could ask about treatments and get information, be asked about their wishes and have questions answered.

However, there were found to be some experiences where participants felt respected as individuals, where they could be responsible for their care, could participate in decisions about care, even if in involuntary care. Sometimes there were discussions between staff and patients about decision that need to be made (Johansson and Lundman, 2002).

Opinions were expressed in terms of there being an over-reliance on medication, and a lack of access to talking treatments, with no effort to help a person understand their mental illness (Secker & Harding, 2002). However, Gilbert, Rose and Slade (2008) found that it was generally accepted that medication was important part of treatment in mental illness.

There was dissatisfaction generally with the information provided on the benefits and side effects of medication. Information was sometimes refused and was provided mainly in leaflet form which was felt inadequate. Some participants had difficulty with concentration or were unable to read or understand the leaflets. They preferred a staff explanation delivered in clear and easily understood manner (Walsh & Boyle 2009: Gilbert et al., 2008). In addition, it was

felt there was not enough information on other therapies that may have been beneficial to relieving distress (Gilbert et al., 2008). Sometimes other activities were offered, but were often seen as boring and predictable.

Line of Argument Synthesis

As Noblit and Hare describe (1988), a line of argument synthesis involves firstly translating the studies identified into one another, which then allows for a second level inference about the relationship between the studies. A grounded theory is developed that puts the similarities and differences between the studies into an interpretation (Noblit & Hare, 1988). To summarise and link the themes identified within the studies, within relationships what seems to be important is a sense that the person has been listened to, has been understood, and is respected as an individual, ultimately they have some influence within the relationship. This is linked to the theme of treatment, where it is again important that person feels listened to about what they think is appropriate or inappropriate treatment. What negates a negative experience is when the person has been forced into receiving treatment that they may see as detrimental to their mental health. They are unable to influence their treatment. In addition, there is a lack of information and a sense of powerlessness here too, as if the person has not been heard in relation to needing information. Within the theme of safety, there a sense of not being able to feel secure while on the ward as there is uncertainty surrounding other service users, whether they will be subject to violence, again it seems as if they have no influence over what will happen to them within their surroundings.

A third order construct proposed here is that of powerlessness. What seems to mediate the perception of a positive or negative experience on an acute psychiatric ward is the sense that a person has been heard, has been understood, and therefore has some influence over their surroundings and treatment on the ward.

DISCUSSION

The findings here largely reflect previous research that service users are mainly dissatisfied with their experiences in acute psychiatric units (see for instance SCMH, 1998). However, unlike much previous research, this synthesis has identified some positive aspects of service users' experiences. This synthesis has therefore attempted to identify overarching themes of the six identified studies and produce a line of argument synthesis that can link the themes. The third order constructs identified are: the importance of relationships, safety and treatment. It should be noted however that the third order constructs are not self-contained categories but are interrelated, and it is suggested that the construct of powerlessness links them. To summarise, the service users seem to have been deprived of control and power over their physical freedom and also by not participating in their care. Indeed, care is experienced as something the service user has no part in, where there is a perception that no one cares or explains what is happening. However, positive experiences can also be explained by the service user feeling that they have been given opportunities to participate in their care and to take on some responsibility for it. Equally, perhaps not participating can be seen as positive to some who may feel too unwell to participate in their care. There is a relief from responsibility. However, as Olofsson, Gilje, Jacobsson and Norberg (1998) suggest, perhaps

restrictions should be removed when no longer necessary. These findings from the meta-synthesis may fit with previous ideas discussed by Beauchamp and Childress (1994) who suggest there are two components for a feeling of autonomy: being independent from controlling action, and a capacity for action.

This synthesis also aimed to assess the quality of the research included in it. This is a difficult undertaking as there is no one method for appraising quality in qualitative research, as this would imply it has a unified aim (Doyle, 2003). The CASP (2010) criteria were used for this and it was found that the studies were of variable quality, but in particular the areas of ethical consideration and the examination of the researchers' relationship with participants are areas for improvement. However, using just one set of criteria can be inappropriate as it is possible the researchers' were of different epistemological positions. Perhaps it would be useful for researchers to state their epistemological position in order for an appropriate appraisal to be carried out.

Before the implications of this are considered, it is important to take into account the methodological limitations. This synthesis only included a small number of studies, and it is difficult to claim that the research strategy employed here will have found all relevant papers. However, the small numbers of appropriate studies found may indicate that this is an under developed area of research. It is also important to acknowledge that the aim of qualitative research is to find meaningful accounts of the subject under study in order to work towards theory development. This may not require a large number of studies. Given the interpretative nature of meta-ethnography, there may be researcher bias that is influencing the emergence of themes. Multiple reviewers may be of benefit in terms of strengthening the findings in future syntheses.

In terms of implications of these findings, the third of construct proposed of powerlessness may in fact mirror the role of staff on acute psychiatric units of custodians. This of course makes it difficult to create a therapeutic environment in which service users are given a choice in their treatment, as outlined in many guidelines, such as the AIMS standards (RCPSYCH, 2010). Perhaps what is needed is for policy makers to be clear about the exact purpose of acute psychiatric units, as outlined by SCMH (2002).

Undoubtedly what is needed is further research investigating service user experiences of psychiatric units in order to explore whether the third order construct proposed of powerlessness is a shared experience among service users. In order to help improve acute psychiatric units, perhaps as Rose et al. (2008) suggest, service users should lead research in order to investigate areas that, from their experience, requires improvement. In addition, as outlined by for instance the DOH (2008) in their publication on involving service users in National Health Service (NHS) improvements, they should have a voice in transforming services in a way that is meaningful to them.

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JOURNAL PAPER

Nurses' Perceptions of Boundaries in Acute Psychiatric Settings*

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STRUCTURED ABSTRACT

Purpose: Service users have cited the importance of professionals relaxing their boundaries in order to improve their experience of recovery. However, concerns about risk dominate in acute mental health inpatient settings. Therefore, this research explored and aimed to theorise how mental health nurses' perceptions of boundaries within this setting may impact on the relaxation of boundaries which service users have outlined as desirable for their recovery.

Methodology: A grounded theory approach was used to interview and analyse data from fourteen mental health nurses.

Findings: Boundaries were perceived to be inherent in the development of mental illness, and thus implementing boundaries for service users was seen as a key part of the nurses' role. However, nurses face dilemmas in what these boundaries are and how they are implemented due to the conflicting discourses of which they are subject to. Setting boundaries is also considered in terms of the process of othering and stigmatisations.

Research Implications: Specific research is called for in terms of elucidating the link between setting boundaries and othering in this setting, as well as

Exploring the discourses that the organisation is responding to when implementing guidelines that may impact on nurses practice.

Practical Implications: Reflective practice and open dialogue approaches are considered to help nurses, and the organisation to reflect on the multiple discourses on which they are drawing upon in their work and which are impacting on their practice.

Value: This research offers a nuanced insight into barriers that may be preventing nurses from adopting recovery oriented practice through consideration of the concept of boundaries, which is key for improving service user experiences of the acute mental health inpatient setting.

Key words: grounded theory, mental health nurses, acute mental health inpatient units, risk, recovery, boundaries, therapeutic relationships, stigma, othering.

Article Classification: Research Paper

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INTRODUCTION

Although recovery oriented practice has been promoted within the United Kingdom, its definition is also increasingly debated within the mental health field. Indeed, it seems to have many meanings, being seen as an idea, a movement, a philosophy, a set of values, a paradigm, policy and doctrine for change (Turner, 2002). Recovery has split opinion, on the one hand being viewed as simplistic, and on the other as revolutionary. However, within the literature, some broad themes have emerged about what qualities service users value from mental health professionals when working in a recovery oriented way. These include hope and optimism, valuing the expertise of the service user, valuing diversity and allowing for risk taking behaviours (Cleary & Dowling, 2009). Indeed, such treatment relationships are key to assist service users in their recovery, and should be developed with individuals who can create an atmosphere of trust, and leave the professional role and do something unexpected (Borg & Kristiansen, 2004).

However, embracing recovery orientated practice may necessitate a shift in values, attitudes and power towards the professional role being facilitative rather than directive, inspiring hope rather than pessimism, and enhancing autonomy rather than taking a paternalistic stance (Sowers, 2005). This shift may involve professionals being able to relinquish responsibility, taking positive risks by handing over responsibility to the service user themselves (Williams & Cormac, 2007). This would involve sharing decision making with service users, thus being flexible with, and perhaps relaxing, rules and boundaries (Baguley, Alexander, Middleton & Hope, 2007). Although defining the term 'boundary' can be difficult, due to it being dependent on the context in which it is being used,

(Zur, 2007), its definition in the broadest sense can be thought of as a limit or a differentiation between two abstract entities. For instance, there may be boundaries about what is deemed to be socially appropriate behaviour and indeed, Gutheil and Gabbard (1993) define boundaries to be the edge of appropriate behaviour. Specifically in relation to this context, Gomm (1996) and Hall (2004) outline that boundaries are a way for professionals to exercise control over behaviours that are deemed to be socially inappropriate. In addition, in this setting where safety is imperative, boundaries may be applied to prevent behaviours that put people at risk of harm, and here, the use of the Mental Health Act can mean that boundaries may include enforcing medication, restraining and holding people against their will in order to maintain safety. Therefore, for the purpose of this research question, boundaries will refer to anything that prevents a behaviour that is deemed to be socially inappropriate, or something that enables nurses to maintain control and thus safety.

This definition may be pertinent to a number of issues within mental health care including physical settings, legal infrastructure and relationships between those providing and receiving care. However, there is a dearth of research relating to the notion of boundaries within mental health services.

The recovery-oriented focus on the promotion of choice, freedom and positive risk taking conflicts with a current preoccupation with risk management, which is reflected in influential policies and guidelines. For instance, standard four of the National Service Framework (Department of Health, 1999) states that crises should be anticipated or prevented, risk should be reduced, and that a delay in the use of medication can lead to poorer outcomes. Further, it has been found that there are public fears as well as fears among families of service users,

that offering choice can increase risks (Jacobsen, 2004). Some professionals may see adopting recovery orientated practices as increasing exposure to risk and liability (Shepherd, Boardman & Slade, 2008), which of course may pose a challenge to the adoption of recovery orientated practice. In addition, the current discourse around blame, in which organisations are aware of their liability to prosecution for exposing its employees to risk (Douglas, 1994), may make it less likely that professionals will take risks in order to work in a recovery oriented way. Therefore, Baguley et al., (2007) hypothesise that what is at the heart of recovery orientated practice (taking risks in order for service users to move towards independence from services), may not be undertaken by professionals for fear of blame if the service user, or others, are harmed.

Working to minimise risk may imply a need for more rigid boundaries, as opposed to relaxing them within recovery oriented practice. Again, by taking the definition of the term boundary in the broadest sense to mean a limit, professionals working within mental health services may be inclined to strengthen boundaries such as monitoring 'compliance to treatment', retaining responsibility for the service user in order to minimise risks.

It is also notable that the perceptions of the risks associated with mental health problems may be biased through processes such as stigma (Corrigan & Penn, 1999) and othering (MacCallum, 2002). Here, people with mental health problems are construed by those without such difficulties as inherently different.

Acute psychiatric inpatient units may be at the heart of the conflict of the two competing discourses of recovery and risk. Among suicides in England and Wales, in 2001 16% were psychiatric inpatients (DoH, 2001). The number of suicides within inpatient settings has been decreasing, perhaps because risk

minimisation of self-harm and completed suicide are a major focus for acute units (Howard, 2004). However, such a culture might limit the opportunities for the implementation of recovery-oriented practice.

Acute units have traditionally been seen as paternalistic, with the view that professionals effect change through the use of medication and treatment programs (Borg & Kristiansen, 2004; Davidson, 2003), with a focus on risk management and treatment rather than recovery (Williams & Cormac, 2007). It has also been suggested that acute units function more to impose social control than to promote recovery (Vassilev & Pilgrim, 2007). It is viewed further that control is exercised by professionals over the behaviours that are deemed socially inappropriate (Gomm, 1996; Hall, 2004). Indeed, there is growing concern evident in the literature that the focus on risk is now central in the provision of mental health care (Muir-Cochrane, Gerace, Mosel, O'Kane, Barkway, Curren et al., 2011).

It is mental health nurses who provide a significant proportion of the care delivered in acute inpatient settings and this is understood to be delivered through interactions with service users (Cleary, Hunt, Horsfall & Deacon, 2012). There is a requirement for boundaries to be in place in order to manage these relationships, however there are additional boundaries specific to acute units. Indeed, given the context within which these nurses work, holding people, sometimes against their will by use of the Mental Health Act, boundaries are likely to form a central part of their role (Cleary et al., 2012). They have to apply boundaries in order to minimise risk in order to maintain safety of the service user and others by for instance enforcing medication, restraining, and holding people against their will, as dictated by the Mental Health Act. Tensions between

freedom and control are ever present in the minds and actions of nurses in this context (Bjorkdah et al., 2010; Delaney & Johnson, 2005; Hall, 2004; Hem et al., 2008). It is within the interactions with service users that nurses may grapple with the dilemma of working with recovery approaches whilst managing the discourses around risk minimisation, and needing to work to strict boundaries in the name of law enforcement (Cleary et al., 2012).

Consideration of the role of boundaries and how they are perceived by nurses within acute units seems fundamental to developing working practices in line with the recovery orientation. Exploring how mental health nurses perceive boundaries within this unique context could illuminate current practices and the apparent dilemmas that nurses face when trying to fulfil competing agendas. Given the socially constructed nature of boundaries, they can be seen as dynamic, with definitions changing and evolving with time according to the cultural and historical context (Zur, 2007). Therefore it is important to specifically explore this context, rather than making broad assumptions and links from other contexts.

To the author's knowledge, although studies have explored the dilemmas that nurses' face in regards to promoting recovery orientated practice whilst minimising risk, no studies have explored the important factors that contribute to staff perceptions of boundaries regarding service users in acute inpatient wards. Nurses are a particularly important staff group as they carry out the majority of therapeutic activity, including forming and maintaining therapeutic relationships, which as noted here has important therapeutic value. The environment of the acute psychiatric inpatient unit is particularly worth exploring in regards to this

given the unique role they play in terms of being therapeutic environments but also where service users may be held against their will.

Aims of the study

The primary aim of the study was to explore the perceptions that mental health nurses hold in relation to boundaries with service users, specifically in the acute mental health inpatient setting. The objectives were to gather detailed qualitative data through semi-structured interviews with mental health nurses working within such a setting and to develop a theory about nurses' perceptions of boundaries within their work, based on the analysis of the data.

METHOD

Grounded theory was used which was considered suitable as there has been little research in this area, and little is known about the topic. In addition, this study is interested in perceptions and experiences, and the research aims to develop new theories (Payne, 2007). Although boundaries can be considered to be a theory laden concept, an inductive approach such as grounded theory is suitable as we do not know how boundaries are perceived with this specific participant group, in the acute inpatient setting. Grounded theory is not one, unitary method, but it provides strategies for seeking and working through data (Charmaz & Henwood, 2008). The guidelines outlined by (Charmaz, 2006) were used throughout the study.

Epistemological position

A social constructionist approach was thought to be most appropriate for this study because boundaries can be considered to be constructed within the social setting. In addition, it could make use of the author's inside experience within the research, and emphasizes the co-construction of meaning between the participants and the researcher (McGeorge, 2011).

Ethical Considerations

Ethical approval was initially gained from the University of Lincoln Ethics Committee (see Appendix A). This research project utilised NHS staff, and therefore, the relevant research and development (R&D) department was contacted for ethical approval too (see Appendix B). All data have been anonymized and identifiable information removed from this report to protect confidentiality.

Participants

Participants were qualified and practising registered mental health nurses (RMNs) working within an NHS acute inpatient unit in the Midlands. Invitations (Appendix C) with Information Sheets (Appendix D) were sent to all RMNs working within this unit. Of the 60 RMNs invited, 14 were willing to engage in an audio- recorded interview. This was sent along with a 'Request for contact from the researcher' (Appendix F).

All participants signed informed consent forms (Appendix E). All participants were given a minimum of 24 hours to make their decision and could

withdraw from study at any point until 72 hours after the interview had taken place.

Demographic data for the participants was not collected for this study. Potentially useful information may have included age and gender, pre-qualification experience, and years qualified, in order to contextualise the data.

Sampling

This study focussed on the views of RMNs working within the acute mental health setting (inpatient services), providing a clear direction for theoretical sampling, which, as Charmaz (2006) writes, involves sampling specific issues to refine categories by seeking precise information to develop emerging theory. This can be achieved by selecting participants who can provide a relevant source of data (Cutcliffe, 2000). Due to being practising RMNs, all participants had knowledge and experience of the topics being explored and so were well placed to discuss the issues under investigation and to contribute to refining the categories. Therefore, a particular participant was not sought out following each interview, but the person who was next available was interviewed.

The aim of theoretical sampling was to achieve 'theoretical sufficiency'. This was deemed to be met within this study after the final interview was analysed, when categories were able to cope adequately with new data without requiring modifications (Dey, 1999).

Procedure

Interviews were conducted in private at the participants' place of work for between 40 and 90 minutes and were digitally audio-recorded. Interview

schedules included broad, open-ended questions. Intensive interviewing techniques were used, which involved asking participants to elaborate on their responses in order to explore areas of interest in more detail. (Charmaz, 2006). Ongoing analysis of interviews influenced the questions being asked in following interviews, which focused on the salient categories from the data (Wimpenny & Gass, 2000).

Data Analyses

Audio recordings were transcribed verbatim. Each interview was analysed using line by line coding prior to the next interview taking place, using Charmaz's (2006) guidelines in order to gain the initial codes. These initial codes stuck closely to the data and the language used by the participants.

The interview schedule was revised after the analysis of the first set of five interviews to further examine, elaborate and refine ideas that had been constructed during the analysis of the previous interviews; and again after the eighth interview. The first five interviews were based on the first schedule (Appendix I); interviews five - eight used the second schedule (Appendix J); interviews eight to fourteen were based on the third schedule (Appendix K).

Focused coding was used to synthesise the data from all interviews, which allowed constant comparison of data and codes constructed from each set of interviews (see Appendix G for an example transcript, along with the initial codes and focussed codes for that transcript). As Charmaz (2006) outlines, this aids decisions about which initial codes make analytic sense to categorise the data incisively and completely in the descriptive categories (Charmaz, 2006). Memo writing was used throughout (Charmaz & Henwood, 2008) to move

between substantive and more abstract modes of theorizing (Henwood, 2006). Theoretical coding involves raising categories to concepts, which are interpretive frames offering an abstract understanding of relationships between categories. In trying to move beyond descriptive illustrations of the codes, consideration was given to the context in which participants existed by drawing on both existing literature and the author's own knowledge and experience. The literature search was conducted to contextualise the data. Much discussion was found in the literature about the role of wider social discourses about mental health, and the role of social control. This prompted questions of the data in relation to whether participants were describing such discourses, for example whether they were incorporating these into everyday practice.

Reflection

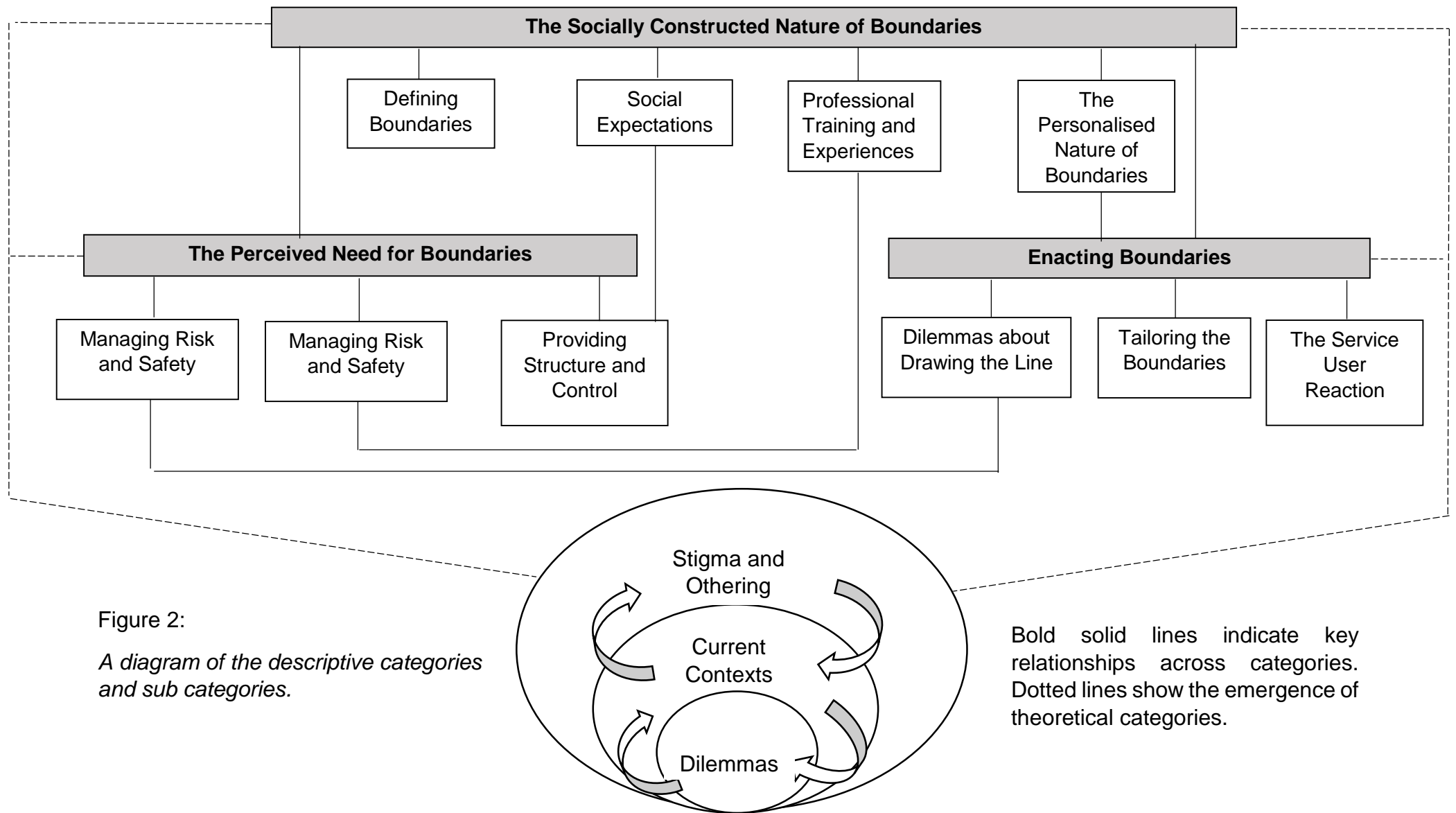
A reflective log was kept throughout the time of development of this study and whilst it was being carried out. This allowed the author to monitor and present steps in the development of the analyses and in developing categories, adding to their grounding (Dey, 2007). Reflexivity allows researchers explicitly to consider the ways in which their preconceptions and experience might have influenced the research process (Yarley, 2008).

Evaluation of the research

Having followed her guidelines throughout, the research was conducted in line with Charmaz's (2006, p.182) evaluation criteria for grounded theory studies. Consideration of the extent to which the research met the criteria is presented in the discussion section.

RESULTS

The initial coding led to the development of three overarching descriptive themes, which each had a number of subthemes. Three theoretical categories were then developed to offer an interpretation of the processes seen within the data. Figure 2 shows the three descriptive categories, their sub categories, and the key relationships between them. This figure also shows the theoretical categories that were abstracted from the data.



The Socially Constructed Nature of Boundaries

It was notable that participants found it difficult to define the term 'boundary'; some were seen to realise this difficulty within the interviews, e.g..

There's, you have to think of everything, I didn't realise it was that in depth (Carol).

Four participants did manage to broadly define the term in relation to providing limits to service users.

I think they're limits that you have to put upon people, especially with regards to the ward environment. It's limits to what they can do, what they can have, to the type of relationship that you can have...(Laura)

The remainder spoke of their perception about the many types of boundaries they deal with in their work:

...there are physical boundaries in the sense of, say the ward environment, where we have a controlled access door. I think that could probably be determined as a boundary...And then, of course, there's boundaries such as Section 17 leave, which are changeable. So we've got the fixed boundaries, we've got the changeable boundaries, and then I suppose as well, we'd look to have individualised boundaries (Trisha).

Participants acknowledged the personalised nature of boundaries and that people are likely to perceive boundaries differently, influencing the way they implement boundaries. They recognised that the development of ideas about boundaries was likely to come from early experiences in childhood, but also acknowledged that their professional training and codes of conduct influence their conceptualisations and thus how they implement of boundaries.

Participants perceived that current policies were likely to be influenced by their practice, and so policies were likely to change depending on incidents involving boundary violations that occurred in their day to day work. However, they also perceived that their practice was influenced by wider contexts, such as the changing culture of healthcare:

I think it can be sort of a cultural change and the way that we perceive healthcare. I think sometimes that boundaries come and go and the way that we deliver inpatient care or the way that we've shifted towards more community based care. And I think that our understanding of mental health and risk, certainly underpins a lot of the work surrounding boundaries. For example, we never used to have intensive care units and we now have intensive care units. We used to have asylums where people were placed for a long period of time. (Mark)

Importantly, participants perceived that their understandings of boundaries were likely to be influenced by what society currently deems as acceptable behaviour versus that which would warrant an implementation of boundaries (such as being admitted to an acute unit):

Well socially, it's all about socialisation I suppose, and what's right and wrong and accepted...You've got sort of Government boundaries, police boundaries, you know, it's all, everybody's got boundaries. And I suppose that's how society functions because there's boundaries there. (Isla)

Across the data set, there were apparent conflicts between policy drivers and other influences that may be impacting on the nurses' day to day practice. For example, they may be attempting to both implement a policy to do with service user inclusion, but also be enacting stringent boundaries due to the perception of risk, heightened by the media.

Therefore, participants acknowledged the personalised nature of boundaries and that there are many things that can influence a person's perception of them, such as early life experiences, social expectations, and training and professional experience, which is likely to explain some of the difficulties nurses had in defining the term boundary.

The Perceived Need for Boundaries

Maintaining the Professional Relationship

The therapeutic relationship was perceived to be key in the recovery process, and seemed to serve many functions for the nurse, such as giving advice to service users about their illness and recovery, and gaining respect from service users in order for them to respect the professional's opinions. Others saw it as an opportunity to create a human connection with the service user and to consider recovery more collaboratively, e.g.:

Just giving them encouragement, you know, discussing what their hopes and dreams are, all that sort of thing. But just talking to them as a human being, as one person to another, not as a member of staff... (Dawn)

Here, Dawn suggests the need to not impose boundaries or power differentials. For most other participants, boundaries within the relationship were perceived to be important for nurses to assert their professional role so service users would not see the relationship as one of friendship. Boundaries were seen to prevent the nurse from becoming too friendly, thus guarding against allegations and protecting their professional registration. Not giving too much personal information away within the relationship was perceived to prevent boundary violations by service users. Nurses seemed concerned that they would be at risk of service users encroaching on their personal lives, or of 'using information against them':

... but I've known one staff member who had a disabled daughter, and he'd spoke about that to other staff and stuff. And then the patient used that against him. And when the patient was shouting and stuff, he was saying, I'm going to find out where you live and get your daughter...(Jenny)

However, a contradiction emerged from the participants as they also perceived that they needed to be able relate to service users on a more personal level too in order to build the therapeutic relationship (please see dilemmas around drawing the line for more detail).

...like you want a patient to, not like you, but respond to you or whatever, so then they're going to listen to you and they're going to take your advice and things like that. But you don't want to over step that mark... But you don't want it to come across as, you want to be friends or you want something more. So it is quite difficult (Jenny).

Providing Structure and Control

All participants had a perception that boundaries were key in the development of mental illness, believing that service users had in some way lost boundaries, or had never had the opportunity to develop them.

...I think people do lose their own, their abilities to self-manage. But I think that changes significantly when somebody comes into hospital. In their own home environment I think it's easy to become chaotic and lose those self-boundaries. (Trisha)

They conceptualised that different expressions of lost boundaries could correspond to different diagnoses, but what linked these differences was a belief that service users do not behave appropriately according to societal expectations. Therefore societal expectations may influence boundaries that are implemented with service users. Given this understanding of mental illness, boundaries were also considered key to the recovery process. Routine and structure that service users were perceived to have lost needed to be re-implemented through the use of a range of boundaries. This appeared to offer the ability to take control where service users were perceived to have lost it. Having a structured environment also allowed nurses to feel

as if they were in control when caring for many different service users with different needs:

You can control it, it gives you an element of control, which is what you need when you're looking after several, well twenty five people's own problems, mental health issues, you do need to be in control because it's a busy environment (Andy).

Despite participants agreeing that structure was an important element of their perception of recovery, there was a concern from all participants about the detrimental impact this may have on service users. In particular, they expressed concern that service users may become institutionalised and dependent on services (as well as individual staff) as service users' choice and freedom was removed.

... I think it can be quite detrimental, institutionalisation and taking away independence from patients, I don't particularly agree with that. I think it may form a reliance on services at times to try and maintain safety, instead of taking that control away from people.(Mark)

They suggested that ultimately the rigidity of the imposed boundaries - particularly removing service users from society, could contribute to the stigmatisation of service users, and to the public perception and fear of those using acute units.

Managing Risk and Safety

In addition to a more general need for structure and control, all participants thought that risk underpinned the need for boundaries within the acute setting,

considering risk of harm to service users, themselves, and to the wider public. Linked with the perceptions of mental illness, there was a sense that risks needed to be removed from service users as it was perceived that they were unable to keep themselves safe:

...when they're unwell, you've got to take that risk away from them, you've got to think for them. But then again, you've still got your therapeutic risks when they are getting better (Carol).

The above quote also illustrates that despite risk and safety being of paramount importance, there again appeared a conflict in that participants recognised the need to take risks in order to for the service user to move towards discharge from the ward.

Participants were also concerned about being blamed for incidents relating to risk and safety, such as suicide attempts or service users' belongings going missing. Participants spoke about this impacting directly on their work and their ability to take positive risks.

...And it's not about positive risk taking, it's not about empowering individuals. It's very much a case of, no you mustn't do that or you mustn't say that. That has to be done in this way because if they say that and we've done that, then we're going to be in big trouble (Trisha).

This strongly suggested a culture in which nurses were likely to impose pre-emptive, strict boundaries in order to protect themselves and their professional identity rather than for the benefit of service users.

Enacting Boundaries

Dilemmas about drawing the line

As noted in maintaining the professional relationship, participants perceived it to be important to cement the roles between themselves and service users. However, they also perceived the need to build the relationship with the service user, which they acknowledged involved sharing personal information.

So I think sometimes you do have to give a little bit of yourself to get things back. But this is where your boundaries come, where you have to be professional. (Isla)

There was clear evidence that participants were aware of a need to be flexible in applying boundaries, but that this posed dilemmas. One participant, Laura, referred to this as a '*balancing act*'. For example, sharing personal information with service users was seen as helping to build the relationship, but how much to share could not be pin pointed by participants. 'Drawing the line' was applied flexibly, depending on the individual nurse and the service user. Getting to know the service user was therefore perceived to be important in order to accomplish where the line should be. Indeed, there seemed to be a process of maintaining strict personal boundaries to start with and then relaxing them as the nurse and the service user got to know each other:

...boundaries develop as the relationship develops. I think you probably start off very boundaried and learn how you work with this person, learn if you click, learn if you can get on with them. And some of the boundaries will maybe change a bit and some will just get discarded completely. (Laura).

In contrast, whilst it was seen to be important to maintain strict boundaries at the start of the relationship, it was also necessary to be flexible and share some personal information first in order to help the therapeutic relationship develop:

So building a relationship with someone, then, obviously, if there's boundaries in place, but if you can almost like loosen them boundaries a little bit, it helps the therapeutic relationship develop (Andy).

However, there was a perception that mental illness could create a barrier to building the relationship:

It's just building that relationship up with them, so that they can trust you enough. And it's very difficult, particularly if they're particularly unwell at the time, because they can't always understand what we're doing and why (Kerry).

It was interesting that this above quote illustrates that not only does the nurse have to get to know the service user, but that there may be a parallel process going on in which the service user needs to get to know the nurse in order for them to trust the nurse. Therefore this does not seem to be a linear process, but one in which both service users and nurses need to allow their boundaries to relax within the relationship in order for it to develop, but they also need to trust each other prior to this taking place.

The Service User Reaction to Boundaries

Thirteen participants commented on the service users' reaction to them implementing boundaries, specifically physical boundaries (such as preventing someone leaving the ward). Participants perceived the reaction (namely anger and aggression) to be due to the service user's mental illness.

I think it's generally upon the individuals and if, what state of acute crisis or mental illness that they're at. I think sometimes it may be perceived that it's exacerbated their reaction to that because they're not particularly very well or they may be acutely unwell. (Andy)

In contrast, there was also a recognition from participants of the service users' perspective:

I mean you've got to remember, someone comes in here and they're probably scared, they're frightened, they're ill, they're in a strange place. They've had their liberty taken away from them, they're going to be angry (Ben).

It was perceived that service user reactions change over time, as they had a 'realisation' that they did need the boundaries to be in place and they were of benefit. Just one participant did not speak of a realisation, but rather of service users just accepting the boundaries as something that they had to put up with:

...but it doesn't take very long before people just do what you ask them to do. I mean it's really quite powerful (Trisha).

Participants thought that service users were unlikely to understand the rationale for boundaries being due to 'mental illness'. However, they also suggested that explaining the boundaries could help the service user to accept them:

Just giving them information and I think that generally is the key thing. Because if somebody doesn't know what's happening, then they get very scared or frightened or angry or, you know, frustrated (Isla).

Some participants suggested that explaining the boundaries offered an opportunity for nurses and service users to work together to find a 'middle ground' (Mark) about what was acceptable for both parties. However, others asserted that no matter what the service user reaction was, the boundaries would remain nevertheless:

...we set boundaries initially from the start, and explain the ward rules, which may be linked to policies. So that's pretty, saying, clear to the patient straight away, they can decide and agree to it or disagree, the boundaries are still in place (Andy).

There did seem to be some inconsistencies between views. For example, while some suggested they themselves set the boundaries, others thought that service users understood that many of the boundaries that were being implemented, such as being forced to stay on the ward, were not actually up to the nurse, but came from a higher authority. Other participants perceived that they were blamed for enforcing boundaries by service users, but felt this was unfair as they felt they were there to care for the service users.

So that can cause a lot of disharmony and fraction between, obviously, service users and care givers. That we're often seen as the ones that are enforcing this, whereas actually we're the care givers and the ones that are there to sort of care for people, as opposed to the ones who are enforcing it. (Mark).

Tailoring the Boundaries

All but one participant discussed tailoring the boundaries to the individual service user, given that all participants were perceived as different:

'...because their own circumstances are unique to them and the risks are different to them, it is flexible in how we deliver those observations or the care to them' (Kerry).

Inherent in tailoring the boundaries to the individual service user, participants cited the importance of considering diversity, which included age, gender, diagnosis, culture and language. Diversity in service users' individual characteristics therefore had an impact on the implementation of boundaries and delivery of care:

'... you wouldn't think twice maybe about an eighty year old who's upset, giving her a little squeeze or whatever. But would you do the same with a fifteen year old boy, well eighteen year old boy...?' (Sarah).

Although tailoring of boundaries was seen as key when enacting boundaries, several nurses spoke of the difficulty of trying to implement different boundaries when catering to different service users':

‘...be aware that other people can see that they’re getting that and they’re having that or they’re not having that, or they might say to them, I’m having that and you’re not, to wind them up. So yes, boundaries can be very difficult to manage on a ward.’ (Ben).

Participants also spoke about the importance of maintaining these tailored boundaries consistently for the service user. Consistency was also referred to in terms of preventing service users with a diagnosis of personality disorder from ‘splitting’ the team. However, as noted by one participant, given that nurses see boundaries differently, maintaining consistency could be difficult.

Theoretical Categories

The themes arising from the data give an insight into the perceptions of the participants. These are set in the unique context of the acute inpatient setting. Using grounded theory means going beyond the description of what is being said by participants to make connections with existing literature, whilst adapting the categories in light of the data. Consideration was given to the extent to which the perceptions were embedded in larger positions, networks, situations and relationships (Charmaz, 2006). Therefore, three theoretical categories were developed to assist the understanding of the perceptions that participants had shared, whilst also considering the context in which participants work. These are outlined below.

Dilemmas

Within the data, there were conflicts in what nurses were reporting regarding boundaries. For instance, whilst there was a need to implement boundaries to maintain safety (such as observations or preventing someone leaving the ward), there was a

recognition that boundaries needed to be relaxed (framed by the nurses as taking therapeutic risks), in order for service users to move towards recovery. Indeed, participants reported a conceptualisation of mental illness as a loss of (or never having had) boundaries. Abstracting from the descriptive codes and inherent in these conflicts is a dilemma that boundaries are applied rigidly to ensure safety. However, if boundaries are applied too tightly, there is a risk that service users will become dependent on services and recovery be impeded as the service user is unable to implement boundaries for themselves. If boundaries are not applied rigidly enough however, there is a concern that the service users may be at increased risk as they are unable to behave in socially acceptable ways and are considered out of control. There is a concern that recovery might not happen as the nurse does not implement the boundaries for service users to take on as part of their recovery.

Current Contexts

The dilemmas are influenced by the contexts in which they are situated, and in turn influence the contexts. Indeed, participants recognised that they are influenced by their professional context, such as the organisation, as well as their professional body and code of conduct, but also that their interactions with service users are likely to in turn influence these broader contexts. For instance participants were aware that practices such as enforced medication may lead to an increased fear of the acute unit by members of the public, thus influencing the social context, however nurses are also likely to be influenced by discourses about people with mental health problems, which leads to their role being concerned with social control.

Othering and Stigma

Within the data, there was a sense of 'us' and 'them', whereby nurses (us) perceived their role to be instilling boundaries into service users (them) who had been perceived to have lost their boundaries (MacCallum, 2002). This process of 'othering' keeps the professional as expert and in a position of dominance, whereas service users are kept within the position of the subordinate. Othering may provide a linguistic boundary for nurses to be separate from the service users and create social distance. As well as the general observation noted within the data of a sense of 'us' and 'them', there were more specific observations in which nurses spoke of maintaining their role as the nurse, rather than being a friend to service users. This process may help to remove the nurse and create distance from those who are considered to be irrational, and reassert their role as sane and dominant. It is perhaps stigmatising views that promote this process of othering and influence the setting of boundaries by helping the nurse to separate from the 'undesired' group' (Link & Phelan, 2006).

However, it is unclear within the data whether participants were aware that these processes may be operating and be contributing to the setting of boundaries. Thus, it may be important to provide space for nurses to reflect on factors that are influencing their implementation of boundaries.

Relationships between the theoretical categories

These theoretical categories were grounded in the data. There is not a sense from the data that there are clear, unidirectional relationships between them. Rather, they represent interacting processes that seem to overlap. For example, taking the dilemma of strengthening or relaxing boundaries, this is likely to reflect wider discourses and contexts regarding needing to minimise risk, whilst also needing to

move the person towards recovery. Inherent here is a conceptualisation that those with mental illness are lacking boundaries, and so they have to be instilled by the professionals who do have boundaries, thus the process of othering can be seen. It may be a way for nurses to help create distance from service users, perhaps because of stigmatising attitudes. Although this psychological process may be operating outside of the awareness of the nurse, it may still create dilemmas as the nurse is aware of the need to relax boundaries in order to move the service user towards recovery. In addition, this is also likely to reflect discourses that those with mental illness are out of control and do not behave according to societal norms, and the professional needs to take control.

DISCUSSION

The research explored '*nurses' perceptions of boundaries with service users in acute mental health settings*'. To summarise the theory, it was found that nurses perceived boundaries to be fundamental to mental health and thus to their role in promoting 'recovery'. Nurses viewed their role as imposing boundaries on those who have either lost them through illness or never had them instilled. However, specifically what these boundaries are or how these should be enforced is ill defined and gives rise to constant dilemmas, reducing hope for the possibility of promoting recovery.

The findings from this study are broadly consistent with existing literature. For instance, opportunities for recovery oriented practice were minimised due to a concern about risk (as found by Howard, 2004), there seemed to be a professional anxiety about the fear of allegations (Baguley et al., 2007), and there was a perception that service users were not acting in socially appropriate ways, and so mental health nurses exercised control (Hall, 2004). In addition, the process of othering was noticed

within the data, in which mental health nurses perceived part of their role to 'treat' service users. However, this research may offer a more nuanced insight through a consideration of the concept of boundaries. Rigid boundaries are perceived as important to manage risk and safety, but also have relational purposes, in that they are perceived to keep the nurse safe from allegations. Therefore, although service users call for a more relaxed approach and opportunities for increased risk taking (Cleary & Dowling, 2009), this possibility may be limited due to nurses' emphasis on rigid boundaries.

As noted, the process of othering seemed to be evident within the data. Discussions within the literature highlight that the mental health profession may 'other' those with mental health difficulties (MacCallum, 2002), and empirical studies have revealed the stigmatising attitudes of mental health professionals (Corrigan & Penn, 1999). However, literature about boundaries within mental health services does not attend to issues of 'othering', that one group of people (mental health nurses) enacting and imposing boundaries onto another group of people (service users) could be seen to be part of a process of othering. This could potentially connect to stigmatising ideas about people with mental health problems, however, further research is required to see the extent to which stigmatising attitudes may be operating within this specific context.

Implications for Practice and Research

It is important to note that a study such as this which uses a social constructionist epistemology does not aim to make claims about what is actually happening in practice. Indeed, it looks at the unique multiple perspectives that people hold. It relies on the assumption that language is constitutive of experience, but does

not demonstrate that people's perspectives are true. It can only assume that it has real world effects. However, other models of research, such as an observational study, would look at the reality of what nurses do in practice.

It is important that the findings from this research are made explicit to those working in this specific setting. As can be seen, there are dilemmas regarding boundaries in practice. By making such findings about dilemmas explicit, it may help mental health nurses to have a more considered response to risk concerns, rather than having a reactive response. Indeed, there needs to be a forum in which nurses feel able to reflect on the limits of their practice because of the multiple discourses which they are having to attend to. Creating a space for openness and reflection may help the mental health nurses to navigate a way through the conflicts which they are subject to.

There is also a risk of practice being narrowed because certain discourses are privileged, particularly those around risk minimisation. A reflective practice space could create a space which allows for reflection, thinking and understanding, and the thoughtful application of skills, knowledge and interventions (Cowdrill & Dannahy, 2008). This has particular implications for clinical psychologists who, as recommended by existing guidelines (British Psychological Society, 2007; 2012), can provide reflective practice spaces, utilising their knowledge of psychological theory to consider how such dilemmas may be impacting on the therapeutic relationships between nurses and service users. In addition, given the variety of conceptualisations of boundaries seen here, there is unlikely to be one view of 'best practice'. Reflective practice and supervision could help people consider how they construct, perceive and implement boundaries in practice.

Alternative models of practice may also offer practical recommendations for nurses in relation to these issues. For example, the 'Open Dialogue' approach (Seikkula, 2011), may offer one way for nurses, other professionals and service users to hold and work with multiple perspectives about boundaries. This may be particularly useful when working with service users who may have a different perceptions of what boundaries are, and how they should be implemented in this context. *Open dialogues* encompass a particular way of working developed in Western Lapland, Finland, and is linked to the dialogical approach of Bakhtin (1984). Within this approach the focus is primarily on promoting dialogue between participants of a network, with the aim of generating a shared understanding of problems and difficulties as they arise, as well as a response to the dilemma in question (Bakhtin, 1984). Thus, creating a safe space for all involved in service users care, including the service user as well as important others, to share dialogue about their individual conceptualisations of boundaries, may ensure that all perspectives are heard in creating a shared understanding that can be implemented when the individual service user is an inpatient on the ward. Giving time to all voices may increase possibilities for the type of recovery oriented practice that service user groups speak of.

However, to create spaces open dialogues, the ward teams may need support from the wider organisation. The organisation may be privileging certain discourses over others in relation to creating guidelines that may be concerned with boundaries. Therefore, it will be important to uncover important discourses the organisation is responding to in terms of boundaries, and to consider organisational change in ensuring that all voices are heard at the organisational level. This may involve including all those who have a stake in guidelines produced by the organisation, and making sure their voices are heard when producing the guidelines. This research

highlights that what happens on wards in the relational space between service users and nurses will impact on the organisation and its responses to these issues. However, responses through guidelines will also impact on nursing practice and service users' experiences. Creating a space for open dialogues may be one way for the organisation to start to create a shared understanding of boundaries implement guidelines that account for multiple perspectives.

This research was deemed necessary because of the unique position that nurses find themselves in acute inpatient wards. However, the participants work within multidisciplinary settings and there may be other professionals in these settings for whom boundaries are an important issue. Further research would be required to establish whether this is the case and whether each profession's guidelines influence their perception of boundaries, as was found to be the case for nurses'. In addition, there may be unique policies and guidelines that influence the nurses within their specific Trust.

Although othering was observed in this study, it was unclear exactly why nurses engaged in this process or the impact it may have on the setting of boundaries in this context. Further research into othering in this context may serve to elucidate the issues of boundaries and recovery oriented practice.

Limitations

As outlined, this research was evaluated utilising Charmaz' (2006) criteria. The claims that can be made from the study are modest, due to limitations such as being confined to one acute inpatient setting, but they are supported by the data. Indeed systematic comparisons were made between the observed data and the descriptive themes throughout the data collection, transcription and analysis of the interviews, for

the results to be grounded in the data. Links were made between individual participants, the organizations in which they exist, and society more broadly.

This study offers a preliminary basis for the development of a theory. The cumulative effect of a number of studies would perhaps strengthen the basis for theory development. However it is important to note that grounded theory, particularly when utilising a social constructionist epistemology does not aim to generalise the findings to broader settings and populations (Thomas & Jones, 2005). Future research therefore should focus on exploring whether the theory could be elaborated on within specific contexts. Further research is also implicated in order to build on the present findings, and could further develop understanding of the organisational issues implicated in the changing service culture. Developing understanding of these issues could help in considering what might be needed to facilitate a cultural change within this setting towards the adoption of recovery oriented practice.

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THE EXTENDED PAPER

INTRODUCTORY SECTION

1.1 Recovery

The concept of recovery began to emerge towards the end of the twentieth century. A new social movement of disaffected service users were sharing their narratives about recovery from severe and enduring mental health problems (Deegan, 1996). This challenged the view that people with mental health problems had a poor prognosis for recovery, marking a resonance of anti-psychiatric ideas (Pilgrim, 2008). There was also a growth of consumerism in the welfare state, with service users being seen more as consumers or clients (Perkins & Repper, 2003). Along with research that highlighted heterogeneous nature of mental illness (Harrison, Hopper, Craig, Laska, Siegel, Wanderling et al. (2001), recovery has become a pervasive concept in services and policies for adult mental health care.

This growing interest in the notion of recovery shows a radical shift from the paternalistic, illness-oriented services, towards collaborative approaches that promote the active participation and autonomy of those who use mental health services (Sowers, 2005). This highlights the shift from service users being seen in a passive and subordinate role, to one that is more powerful in which the service user takes greater responsibility for their own care (Roe & Davidson, 2008).

Despite what seems to be an increasing commitment to the concept, there is little consensus on what it actually means in relation to mental illness (Davidson & Roe, 2007). Bellack (2006) states that recovery is at risk of being defined too stringently, so that it becomes an impossible goal, or so broadly that its achievement is unimportant and difficult to implement. Indeed, recovery does not seem to be well understood by service users who are expected to recover, or by professionals who are

expected to help them (Jacobson & Greenley, 2001). A range of definitions of recovery and discussion around related issues will now be presented.

Davidson and Roe (2007) recognise that recovery does not require 'clinical recovery' or the service user to be symptom free. They distinguish between 'recovery from' and 'recovery in'. The former is when people with a diagnosis of a severe mental illness become symptom free, and thus do not return to the patient role. The latter is when mental illness is viewed as a set of long term conditions that people live with every day and try to progress from, despite their vulnerability to relapse or the presence of ongoing symptoms. It is therefore not about cure, but about trying to endure and manage the illness (Davidson & Roe, 2007).

Pilgrim (2008) differentiates between three notions of recovery. The first is based on the bio-psycho-social model of treatment, in which service users are able to recover from a biologically determined illness via treatment. Although this seems to be against the therapeutic pessimism of biological psychiatry, it does not necessarily undermine the traditional bio-medical confidence in diagnostic categories and the paternalistic treatment focus (Pilgrim, 2008). The second approach is associated with the community orientated social psychiatry, where supportive and personally tailored skills training enable service users to stay out of hospital, and to maximise their ability to socially integrate by complying with service expectations about improvement (Pilgrim, 2008). In these first two notions, Pilgrim (2008) argues that standard medical treatment or psychosocial interventions are thought to lead to symptom reduction or the reversal of impairment. The actions of the professional are seen as benign, warranted, required and effective, such that civil rights violations and clinical iatrogenesis are regrettable but necessary to ensure good care (Pilgrim, 2008). Indeed, within this conceptualisation of recovery, it is likely that mental health workers

will still monitor risk, compliance with medication and relapse (Bonney & Stickley, 2008), and it is argued by some that this statutory emphasis on maintenance and relapse prevention is contrary to the notion of recovery (May, 2000).

The third approach centres on service users who demand freedom from services, and aspire to be self-determining in life choices. Social rejection is challenged and there is an emphasis on experts by experience, such that the true authority for recovery resides within 'psychiatric survivors' (Padilla, 2001; Pilgrim, 2008). In this notion of recovery, there is also a focus on stigma and social exclusion that results from being a service user. Here, coercion and clinical iatrogenesis are regular points of grievance, and are not seen as necessary to ensure good care.

Meagher (2004) defines recovery by six basic features: remaining hopeful for future growth and personal development; having the right to choose; knowing that you are a person and not a diagnosis; speaking for yourself rather than being devalued by others speaking for you; living in a place of one's choice; and emphasising the need for personal support and intimacy. These features may be at odds with the professional emphasis on accurate diagnosis, medication compliance, risk management and care plans. Indeed some of these aspects are ignored or challenged in the above definition (Pilgrim, 2008).

As Pilgrim (2005) outlines, as a result of the discursive shifts, there are a range of ideological positions about recovery. On one end of the spectrum, some service users accept the bio-medical definitions of diagnosis and treatment and simply demand best practice. At the other end, service users campaign for the abolition of psychiatry and dedicated mental health legislation, and in between are views about reducing medication and coercion and increasing patient centred care. This highlights that ideas relating to recovery are influenced by different values that are held

legitimately by different stakeholders, including the individual service user, providers, carers, and others (Bellack, 2006). This may give rise to dilemmas and challenges in developing different approaches that integrate the different views and needs of each group, and individuals within these groups.

As well as highlighting the views of different stakeholders, the above definitions also highlight the issue as to whether recovery is an outcome with an end point, or a process. Some suggest that it could be both, whereas others state that it is a process (Deegan, 1996). Deegan (1996) refers to recovery as a journey that is not linear, and importantly, is unique to each person. Indeed, these discussions highlight that attempting to define the concept of recovery is a complex and ongoing task. Many argue that recovery is not about cure, but acknowledge that it may be referred to in these terms (May, 2001; Rethink, 2005; Sayce, 2000). However, it is unlikely that a shared definition of such a complex concept can be achieved any time in the near future (Pilgrim, 2009). However, considering the concept of recovery and the emphasis on service user choice, it would seem important for the definition of recovery to be meaningful to the individual service user to whom it refers. Indeed, imposing a definition could be considered as oppressing the voice of the service user, something that recovery approaches are actively engaged in moving away from.

Service users speak of the importance of relationships and the relaxation of boundaries within them to help the service user move towards recovery. In particular service users outline the importance of mental health professionals going beyond what is defined as their usual role (Borg & Kristiansen, 2004). However, within this, service users do not speak of a clear definition of boundaries, and do not offer concrete suggestions for how this might be achieved in practice. Defining the term boundary can be problematic (see section on the definition of boundaries). However as

suggested by Zur (2007), what unifies all definitions is the essential aspect that they differentiate between two or more physical – actual or elusive – abstract entities. Therefore, when working in recovery oriented ways, professionals may need to relax the boundary around their professional role in order to allow the service user more choice and freedom to work towards their own definition of recovery. This may require services to move beyond their emphasis on risk avoidance towards a creative risk taking that is meaningful to the service user. This is consistent with the suggestion in the CSIP/RCP/SCIE (2007) principles of recovery oriented care. However, there is a lack of consideration about perceptions of different types of boundaries and their relationship to recovery oriented practice. Nurses will therefore have to develop their own practice, without a reliable evidence base to draw on.

1.2 Risk in mental health settings

Risk can be described as “the likelihood of an adverse event happening” (Muir-Cochrane & Wand, 2005, p. 5), and Oxford Dictionaries define risk as a situation involving exposure to danger (noun), or to expose someone to danger, harm or loss (verb) (<http://www.oxforddictionaries.com>).

The focus on risk in the provision of mental health care is believed to have arisen out of a complex set of social, political, and economic changes (Muir-Cochrane, Gerace, Mosel, O’Kane, Barkway, Curren et al., 2011). Muir-Cochrane et al., (2011) outline that this includes the adoption of market-based principles in the provision of health care and a consequent focus on the use of managerial techniques to optimise organisational performance (Alaszewski, 2005). This was underpinned by the current framework of a risk averse culture within society more generally (Cleary, Hunt, Walter, & Robertson, 2009).

Within this context of risk aversion, there is a general perception that all risks can and should be identified and ameliorated. Indeed, it is suggested that when discussing risk, it should be in quantitative terms to avoid uncertainty (Chicken & Posner, 1998). However, this implies that risk is something that can be identified, quantified and 'known' with certainty. In contrast to this position, outcomes are often unpredictable and circumstances surrounding risk idiosyncratic. As Carsten Stahl et al., (2003) suggest, thinking that risk is something that is objective limits the potential to address risks specific to organisations and situations.

Thinking about the conceptualisation of risk in society more broadly Luhmann (1993) furthers that strategies used to cope with risk attempt to bring control to uncertainty, but actually can have the effect of increasing anxiety about risk because of their focus on concern. Thus day-to-day life may not be more risky now than previously, but thinking in terms of risk is ever present in current society (Giddens 1993). Therefore, Douglas (1994) argues that now, institutions are aware of their liability to prosecution for exposing its employees to risk, therefore they try to make its users liable for damage they cause. She furthers that we are currently in a blaming system which firstly asks who is to blame, and then what action needs to be taken. Thus organisations such as the NHS, are cautious in order to avoid prosecution for negligence. It is likely that social changes in the use of the term risk and awareness of liability are reflected in mental health services (Douglas, 1994).

Returning to focus on mental health services, the management of risk in the mental health field has received much attention in recent years (Duffy, Doyle & Ryan, 2004). Vassilev and Pilgrim (2007) write that mental health services do not in fact promote mental health, but are concerned instead with managing mental disorder in order to minimise risk. Considering acute inpatients units specifically, if the primary

concern is as Vassilev and Pligrim (2007) state, then boundaries within this setting could be key. Many of the practices within this setting, such as enforcing treatment, deprivation of liberty and restraint could be perceived to be concrete examples of setting boundaries or limits. Here, boundaries could be implemented to put a limit on a behaviour that is deemed inappropriate (Gomm, 1996; Hall, 2004), or to enforce the difference between roles of the professional and the service user, maintaining the discourse that service users need to be treated. This may actually increase the risk of service users being disempowered and becoming dependent upon the mental health system (Ryan, 1998), therefore reducing opportunities for recovery.

Risks in mental health services can include patient aggression (Daffern & Howells, 2009), suicide and self-harm (Thompson, Powis, & Carradice, 2008), absconding (Muir-Cochrane, Mosel, Gerace, Esterman, & Bowers, 2011), substance abuse (Thomson, 1999), and diverse concerns, such as medical co-morbidity, exploitation, social exclusion, victimization, and poverty (Kelly & McKenna, 2004; Muir-Cochrane 2006). However, when considering how professionals conceptualise risk, Langan (2008) found that this was in terms of risk to others, risk to self, and risk arising from vulnerability. Risks arising from stigma, social exclusion, racism, sexual abuse or iatrogenic effects of psychiatric treatment were not considered. This is despite the Care Programme Approach highlighting that risk should not only be considered an assessment of the danger an individual service user poses but also wider social, family and welfare circumstances (Department of Health, 1999). This is likely to have an impact on a person's recovery, given that some see recovery as recovery from stigma, social exclusion, labelling, restriction and discrimination (Sayce, 2000; Hope, 2004).

The increasing importance placed on risk assessment and management is not only reflected in policy, but also in the daily care of consumers by mental health care

professionals (Department of Health, 2007; Langan, 2010). This has led to much discussion about the best approach for assessing the risks posed by individuals with mental health problems; this includes the risks to both themselves and others. The central role of a risk management approach to the provision of health care has raised a number of tensions for service providers and researchers. Concerns have been expressed that clinical practice is being dominated by a managerial model of risk management, at the expense of meeting the patient's mental health needs (Godin, 2004). There are issues associated with potential iatrogenic effects of risk management, such as the risks posed to patients by prescribed medications (Pilgrim, 2008). The increased focus on risk management would be likely to lead to an increase in the imposition of boundaries onto service users, which in turn could be likely to paradoxically impede recovery oriented practice.

Section 1.3 - Othering and Stigma

Othering is a process that identifies those who are thought to be different from oneself or the mainstream, and it can reinforce and reproduce positions of domination and subordination (Johnson, Bottorf, Browne, Grewal, Hilton & Clarke, 2004). It is not only thought to mark and name those thought to be different from oneself, it is also a process through which people construct their own identities in relation to others (Weis, 1995). By talking about individuals or groups as 'other', apparent differences can be magnified. The other is usually attributed a negative value, and the same as a positive value (Carabine, 1996).

Considering the mental health setting, the extent that professional power and distance is maintained in order to prove that the 'other' is irrational could be seen to maintain the professionals' sense of integrity and sanity (MacCallum, 2002). More

specifically in mental health care, othering maintains the service user as other and mentally ill, and reasserts the professionals' sanity and power (Rudman, 1996; MacCallum, 2002). An important aspect of othering is that it is not considered or recognised as such by those enacting the process. Although as Seidman (1994) highlights, professionals working within mental health and enacting othering processes may believe there to be truth in their assumptions. However, these accounts only serve to express the social positioning of the professional. Othering may either lead to or require limits to be set between one group and the other, in order to maintain the distinction between the two. Such a process may contribute to the setting of boundaries, in addition to legal requirements.

Stigma is a collection of a 'negative attitudes, beliefs, thoughts and behaviours that influence the individual, or the general public, to fear, reject, avoid, be prejudiced and discriminate against people' (Gary, 2005, p. 980). There is an increasing literature on the stigmatizing attitudes towards people with mental health problems (Henderson & Thornicroft, 2009), held by both the general public and professionals (Corrigan & Penn, 1999). Views include that people with mental health problems are unpredictable (Magliano, Fiorillo, De Rosa, Malangone & Mai, 2004), that they should be avoided (Nordt, Rossler & Lauber, 2006), that they are unlikely to recover (Hugo, 2001), that they are weird (Loch, Hengartner, Guarniero, Lawson, Wang, Gattaz et al., 2013), needy and dependent, dangerous and prone to violence (Angermey & Dietrich, 2006). The affective responses towards those with mental illness are fear and uncertainty and they thus avoid social interaction. Stigmatising views may promote othering between those who hold the views and those who the views are held about.

Stigmatising attitudes erode self-esteem, creativity and empowerment, which as Perese (2007) outlines, are important aspects for recovery. These attitudes also

lead to marginalisation, placing distance between a person and the resources they need for social connection (Perese, 2007). Importantly, these attitudes may threaten the nurses' relationship with the service user, as interacting with an individual while holding stigmatising assumptions may involve focussing on one aspect of their identity and not attending to others (Horsfall, Clearly & Hunt, 2010). Stigmatising views are likely to have implications for the construction of risk in relation to people who access mental health services and thus, have implications for perceptions of the possibility of recovery.

Social cognitive models describe how stigma related processes are formed and maintained. There are three components that make up this model: stereotypes, prejudices and discrimination (Corrigan, Kerr & Knudsen, 2005). Stereotypes are described as the knowledge structures that are learned by most members of a given social group (Hilton & von Hippel, 1996). Stereotypes are an efficient way of categorizing information about social groups. They are social because they represent collectively agreed upon notions about groups of people and they are efficient because people can quickly generate impressions and expectations of people who belong to stereotyped groups (Hamilton & Sherman, 1994). Categorization functions as a way for people to organize the large amount of information encountered in everyday life (Eagly & Chaiken, 1993). Common stereotypes are that people with mental health problems are dangerous, incompetent and are weak (Corrigan et al., 2005).

People who endorse these negative stereotypes are referred to as prejudiced. They may hold a stereotype that all people with a mental illness are violent. This may generate a negative emotional reaction as a result, such as 'they all scare me'. Prejudicial attitudes involve agreement with an evaluative component (that is generally negative). Prejudice, which is fundamentally a cognitive and affective response, may

or may not lead to discrimination, the behavioural reaction (Corrigan et al., 2005). Prejudice that leads to anger can lead to hostile discrimination, such as physically harming a minority (Weiner, 1995). Corrigan (2000) reports that it may even lead to withholding of mental health care. Implementing boundaries could be considered to be an example of a behavioural reaction, or discrimination.

Stigma and mental health professionals

It might be expected that mental health professionals would demonstrate low levels of stigma, having chosen to work with individuals with mental health difficulties. Indeed, contact theory hypothesises that contact with a person with a negative stereotype attached to them is likely to reduce the negativity of that stereotype (Corrigan, 2005). However, people with mental health disorders have reported that contact with mental health professionals was perceived as a stigmatising experience (Schulze & Angermeyer, 2003).

Llerena (2002) suggests that this may be as a result of mental health professionals being mostly confronted with services users at an acute stage of their illness, and thus knowledge and experiences of the symptoms associated with the acute phase of the illness could be associated with an increase in stigmatising attitudes. Thornicroft (2006) furthers that many professionals rarely see people who are successfully managing their illness. They are more likely to see people who have relapsed, therefore skewing their view of prognosis. Alternatively, Major and O'Brien (2005) suggest that the contact that mental health professionals have with service users provides excessive closeness and an undesired group identification. These stereotype attributions are typically thought to come as a response to help separate from the undesired group (Link & Phelan, 2006). Implementing boundaries may be

one way of achieving the separation. Hence it is important to understand nurses' perceptions of boundaries.

The beliefs that mental health professionals hold about users of mental health services are very important for the interactions and treatments that service users receive. The stigmatising beliefs that mental health professionals hold, such that the service user is responsible for their condition, can cause feelings of anger towards them, and there can therefore be a reduction in the assistance that they gain from others (Llerena, 2002).

Horsfall et al. (2010) outlined that mental health nurses themselves hold some of the same stigma related beliefs as the rest of society, which has implications for recovery orientated practice. Manifestations of stigma can be outward or discrete and may include negative, hostile and derogatory language, as well as disrespect in personal relationships and behaviour (Deegan, 2007), and can impact on shared decision making and the exercise of power (Cutcliffe & Happell, 2009). Thus, the impact of these stigmatising attitudes can go against the principles of recovery, which include hope, a rediscovering of personal strengths and finding purpose and meaning in life (Onken, Craig, Ridgway, Ralph & Cook, 2007).

The stigmatising attitudes that mental health professionals hold are likely to impact on the relationship they have with service users. Henry, von Hippel and Shapiro (2010) found that people with a diagnosis of schizophrenia have difficulty with social functioning, which is in part due to their awareness that others know of their diagnosis. Therefore, the extent to which one is able to enjoy and feel comfortable in an interaction is an important determinant of willingness to engage in future interactions with that person (John & Gross, 2004), which can mean that the very thing that service users cite as important for their recovery, relationships, are avoided. Therefore, it is

important to understand the attitudes and beliefs of professionals as it is known that the actual behaviour of psychiatric staff are associated with treatment outcome (Lauber, Nordt, Satorius, Falcato & Rossler, 2000).

Both othering and stigma are processes by which those working within the mental health setting can be perceived to be creating a social distance from service users, who are considered mentally ill by those in the position of power. Although not necessarily conscious processes, these may serve as ways of implementing boundaries in order to create social distance. However, this can currently only be hypothesised as research has not investigated whether nurses are aware of the possibility of such processes.

1.4 Risk, recovery and relationships

Recovery principles can be seen to focus on the service user's goals, potential for change and growth, and a transparent and collaborative relationship with health care professionals (Barker & Buchanan-Barker, 2005). Indeed, the importance of the interpersonal relationship between professional and service user is well documented (Smith, 2000), with a central component of reciprocity (Bigwood & Crowe, 2008). However, inherent in recovery principles is the notion of risk taking (Ramon, Healy & Renouf, 2007). A challenge therefore exists in the implementation of a balance between a focus on the risk a service user is seen to pose, particularly in areas where risk to others and self is involved, and the development of "a respectful and considered therapeutic relationship [which] assists the patient to achieve a sense of ownership and responsibility for their mental illness, treatment and risk management" (Kelly, Simmons, & Gregory, 2002, p. 208).

When considering the role of the mental health nurse in acute inpatient settings, it has been found that they perceive limit setting interventions to be key, seeing their role as corrective with an emphasis on changing the service user through external control (Salas & Fenton, 2000). Muir-Cochrane (1996) has further found that coercive practices, such as seclusion was used rather than relational strategies. In these studies it seems that a framework of power and control underpins the nurses' perceptions of their role, which is in contrast to recovery oriented philosophies. However, this is reflective of the wider perception of the purpose of acute inpatient units, which is to minimise risk. Practices used under the Mental Health Act, such as restraint and seclusion, as well as the perception that nurses' have of their role indicate that it is perceived that the service user lacks capacity to make appropriate judgements that will keep themselves and others safe, and that control therefore needs to be taken from them. Indeed, such practices are associated with an expectation in the culture of the acute inpatient setting that nurses need to maintain control (Bigwood & Crowe, 2009).

Some perceive that the work that mental health nurses carry out in this setting, especially under the Mental Health Act, is a custodial activity with the work of mental health nurses is embedded in a larger narrative of psychiatric medicine and its social control function (Morrall, 1998). Examining the literature, it seems that the attempts to move mental health nursing from a primarily custodial activity to a therapeutic one has a long history. As the threshold for admission to acute inpatient units has risen as a result of a move to the community model of care, the ward environment has become increasingly disturbed, chaotic and over-occupied (Quirk & Lelliot, 2001). There seems to be a consensus that 'humane custody' (Goodwin, 1997), which was hoped to reduce as a result of de-institutionalisation, has not been diminishing as a result of

these changes. Deacon (2003) argues that custodial nursing means that service users are not free to come and go on acute inpatient units, even those who are not formally held by law. If nurses were not to know where service users were, their practice may be called into question by their employers, and the public. It could therefore be argued that all service users on acute wards are, to varying degrees, in custody, and therefore nurses are their custodians (Deacon, 2003).

Given that one of the key tasks of mental health nurses in this setting is the formation of a therapeutic relationship, whilst also being required to enforce 'humane custody', a relationship that is built upon collaboration and trust may be difficult given that the partners are overseen and over-seer (Watkins, 2001). As Clarke (1999) outlines, mental health nurses are therefore confronted with the dilemma of having the intention to care for service users, whilst having a requirement to police them. A custodial approach, aiming at reducing risk and at prevention at any cost is not appropriate, given that it is likely to impact on the therapeutic relationship which is so important within the setting (Duffy et al., 2004).

Morgan (1979) has written of 'malignant alienation' whereby a number of his own inpatients appeared to have killed themselves following a progressive deterioration in their relationship with others, including ward staff. Duffy et al., (2004) hypothesise that one of the reasons for such deterioration in relationships is counter transference, where by negative attitudes of unconscious malice or aversion are communicated to the patient by staff who are responding to feelings of anxiety or helplessness which the patient has awakened in them (Watts & Morgan, 1994). However, this highlights the importance of the quality of the therapeutic relationship between the nurse and service user. A relationship characterised by a preoccupation with risk and thus control may lead to low self-esteem and morale, exacerbated due

to communication of distrust, infantilisation and denial of personal rights, whereas if care is emphasised without appropriate vigilance then the results may be tragic (Duffy et al., 2004).

Nurses themselves have spoken about their perception of controlling practices. Bigwood and Crowe (2009) found that although they perceive controlling practices, such as restraining service users, to be part of their job, they are still uncomfortable with their use. Thus nurses seem to be caught between trying to be therapeutic whilst having to maintain the safety of service users and staff.

Therefore, there seems to be a tension between nurses needing to minimise risk by maintaining safety, which can entail using controlling practices including implementing boundaries with a service user or in the environment to limit a behaviour. This is in contrast however to recovery oriented practices in which professionals are required to promote choice, freedom and independence which would entail relaxing the relational boundaries around their professional role.

1.5 Boundaries and the therapeutic relationship

Boundaries can have multiple meanings and implications, and as outlined by Zur (2007) have been defined, discussed and applied differently by different people in different situations. Although there are concrete/physical boundaries, such as borders between regions, other boundaries are more abstract such as social, racial, interpersonal, interpsychic and spiritual boundaries. For instance, there may be boundaries about what is socially acceptable behaviour. What unifies all definitions is the essential aspect that they differentiate between two or more physical – actual or elusive – abstract entities (Zur, 2007). More specifically, personal boundaries can be defined as guidelines, rules or limits that a person creates to identify for themselves

what are reasonable, safe and permissible ways for other people to behave around him or her and how they will respond when someone steps outside those limits (Katherine, 2012).

In therapeutic relationships, boundaries are traditionally seen as enabling a process of exclusion and separation (Rodgers, 2009). They exclude inappropriate social, sexual, or other exploitative behaviours from the therapeutic relationship (Speight, 2011). They also separate the relationship from others types of relationships in terms of professional issues such as confidentiality (Rodgers, 2009: Zur 2007). However, they also function to enable meeting and connection, and Rodgers (2009) outlines that without boundaries there would be merging rather than meeting. The clinician is expected to maintain an objective, professional distance while developing an effective working relationship with the clients (Speight, 2011).

These definitions also do not acknowledge that different orientations and different eras have thought of, defined, and implemented boundaries differently. For instance, some clinicians emphasise the importance of clearly defined and consistently used boundaries, whereas others stress the importance of dismantling certain boundaries. Thus, because what constitutes a boundary in therapy varies among practitioners and orientations, its definition becomes difficult. Smith and Fitzpatrick (1995) discuss it in terms of a therapeutic frame which defines a set of roles for the participants in the therapeutic process, whereas Gutheil and Gabbard (1993) regard boundaries as the edge of appropriate behaviour. Within these definitions it is not clear whose responsibility maintaining these boundaries is. It is assumed by some that is the responsibility of the clinician, however it should be acknowledged that the client contributes and defines the nature and development of therapeutic boundaries (Knapp & Slattery, 2004). Within the context of the acute inpatient setting, the mental

health nurses are also trying to create therapeutic relationships. However, in these contexts there is much more contact with service users than in therapy where contact may be limited to one hour per week. Not only are service users dependent on the nursing staff to meet their therapeutic needs, they are also dependent on them for the most basic care needs. In addition, most of the literature relating to therapeutic relationships has not been developed with reference to individuals considered to be acutely mentally unwell. Thus while these ideas about boundaries within the therapeutic relationship are important to consider when thinking about inpatient settings, they are limited in their application. Specific research is therefore required that focuses on boundaries within the relationships between nurses and service users in acute inpatient settings.

A boundary violation can be defined as an event that occurs whenever the therapist responds to their own needs, failing to act in the best interests of the client (Hartmann, 1997), and Zur (2007) adds that the therapist misuses his or her power to exploit or harm a client. Boundaries are therefore seen to be a crucial component of the therapeutic relationship to keep both the client and the therapist safe. The containment that boundaries provide is thought to provide a safety which allows clients to think about doing something differently (Rodgers, 2009). However, although standards that define what a boundary violation is are of high importance, again, they are not easily defined, and it is likely to be a dynamic standard that changes and evolves with time, similarly to the definition of boundaries themselves. A review of the literature has revealed that there is only a basic agreement to do no harm, to eschew exploitation of clients, and to respect clients' autonomy, dignity and privacy (Zur, 2007; Gutheil & Brodsky, 2011; Rodgers, 2009).

Boundary crossings are also worth considering here, as unlike boundary violations, they can be part of a well-constructed treatment plan designed specifically to increase therapeutic effectiveness. However, risk management concerns have been emerging and has shifted the interpretation of what constitutes a boundary crossing towards a more cautious approach. This is despite a significant number of publications that link boundary crossings to the most commonly practised theoretical orientations and review their potential clinical benefits (Lazarus & Zur, 2002; Schank & Skovholt, 2006). As Gutheil and Brodsky (2011) outline these two forces have been operating simultaneously and pulling standards of care in different directions. Risk management practises lead to more practitioners acting defensively, whilst the emergence of a more open approach tilts the standard to a more flexible, context based standard.

Within the healthcare context risk management generally refers to the practice of minimising risks involving risk identification, risk assessment, risk analysis and risk control. Reducing the risks to clients is an ethical and professional commitment outlined in nearly all codes of conduct, under the general principle of non-maleficence, and is the therapists' clinical, ethical and legal obligation to minimize the risk of clients who are mentally ill hurting themselves or others (Zur, 2007). However, there is debate as to whether risk management practices are aimed at protecting the practitioners or the clients. For instance, Williams (1997) defined risk management whereby clinicians refrain from implementing certain interventions because they may be misinterpreted, questioned or frowned upon by professional boards. The aim seems to be to prevent, or pre-emptively defend the health care provider against allegations (Rowan & Jacobs, 2002). The literature does not seem to focus on inpatient settings, and as there are specific challenges to such settings, further research is necessary.

It could be seen however that excessive focus on a clinician's safety results in a neglect of the client's needs. Indeed, Lewin (1994) states that the most common boundary violations are probably ones of excessive distance rather than ones of over involvement, such as not comforting a distressed client or avoiding a potentially useful self-disclosure (Gutheil & Brodsky, 2011; Lazarus, 1994, 2007).

When examining the broader context of risk aversion, it is unsurprising that there is the current discourse within working therapeutically of sticking rigidly to boundaries. As Speight (2011) outlines, from a purely risk management perspective, the clinician would be wise to avoid any boundary alteration or crossing since it could lead to negative and potentially dangerous consequences for client and therapist. Indeed, mental health professionals are seen as responsible for establishing and strictly maintaining the boundaries of therapeutic relationships. This conservative view, with a focus on risk, has greatly influenced how the field conceptualizes and discusses boundaries (Speight, 2011). Therefore, clear boundaries are seen to be critical for an effective therapeutic relationship, and the altering of boundaries is avoided because of the real danger of client exploitation. Boundary crossings are not discussed as being beneficial or therapeutic, which is likely to result in a sterile and artificial relationship, which lacks what helps it to be clinically effective (Lazarus, 2007). It could be considered therefore that a preoccupation with risk and safety is not allowing a relaxation of boundaries within clinician and service user relationships. This could be key for the formation of therapeutic relationships that are valued by service users, and cited as one of the key components to recovery.

Thinking more broadly, it could be considered that we live in an individualistic society, with narrow, short term self-interests (Rodger, 2003). Rodger (2003) furthers that within this society, false niceness and social restraint prevent emotional

connection. We are therefore able to keep human suffering out of our direct experience. Knowledge of those who are oppressed and disadvantaged is gained from a safe distance, cultivating a detached concern. It is interesting that this detachment is often seen as a key characteristic of being an objective and effective mental health professional (Speight, 2011). Considering recovery orientations however, there is a need for flexibility, and the above therefore poses challenges to developing relationships that will promote recovery.

METHOD

2.1 Research design

Grounded theory is a popular and widely used method of qualitative inquiry (Bryant & Charmaz, 2007). Charmaz's (2006) constructive conceptualisation of the grounded theory method was used for this study. This offers systematic but flexible guidelines for collecting and analysing qualitative data to construct theories grounded in the data themselves (Charmaz, 2006), rather than deducing testable hypotheses from existing theories (Glasser & Strauss, 1967), as seen in more traditional positivist approaches.

In this method, the importance of going inside the studied phenomenon and gathering extensive, detailed descriptions about it whilst using grounded theory strategies to direct data collection is advocated (Charmaz, 2003). This is important because such data reveals participants' thoughts, feelings, intentions and actions as well as context and structure. Given the importance of gaining detailed data, semi-structured interviews were used for the data collection method for this study. This has been a useful data gathering method in various types of qualitative research, and is described as a directed conversation (Lofland & Lofland, 1995). As Charmaz (2003:

2006) explains, interviews are semi-structured in that the researcher may have an idea of the area of interest and some broad, open ended questions to pursue, but there is also a wish to try and enter the psychological and social world of the participant.

Grounded theory incorporates a cycle that incorporates data collection, coding, analysis, writing, design, theoretical categorisation, and data collection (Hood, 2007). It involves constant comparative analyses of cases with each other and with theoretical categories. The theory is inductively developed from the data and is continuously refined (grounded) by data. The resulting theory therefore accounts for all variations in the data and the report is an analytic product rather than a descriptive account (Hood, 2007).

2.2 Other methods of data analysis considered

Other approaches to qualitative research were considered for this study. For instance, thematic analysis, as outlined by Braun and Clarke (2006), would enable the development of descriptive themes based on the content of the semi-structured interviews. However, this may not consider and capture the relationships between them, and the processes underlying these categories, which would not lead to development of theory. As the aim of this research was to develop a theory based on nurses' perceptions of boundaries, this qualitative research method was excluded.

Interpretative phenomenological analysis (IPA; Smith, 2004) explores how participants make sense of their personal and social world, studying the meanings that experiences hold for participants. It explores personal experiences and is concerned with a participant's own perceptions of an object or event. It also acknowledges that research is a dynamic process, and that the researcher's own conceptions are required to make sense of the participant's personal world. As IPA explores

idiographic, subjective experiences and does not seek to generate general traits or principles, this qualitative methodology was thought not to be able to meet the research aims of this study.

Another method that was considered was conversation, described by Drew (2008). This analysis does not just view talk as a means of communication, but also as action, and captures the aspects of interaction that are concerned with process (Drew, 2008). However, extensive grounding in this method is required, and given the time-limited nature of this research project it was felt that to carry out a rigorous piece of research would not be possible.

Therefore, although other research methods were considered, as the aim of this study was to construct a theory, grounded theory was deemed to be the most appropriate research method.

2.3 Epistemological position

As outlined in the methodology section, the lack of existing theory has led to the identification of grounded theory as the most appropriate form of methodology for this study. Since the creation of grounded theory (Glaser & Strauss, 1967), it has experienced differences in application and development. Initially, creators of grounded theory, Glaser and Strauss, worked within the post-positivist ontological tradition, which posited that observed reality is an expression for, or a sign of, deeper lying processes. This is rooted in critical realism (Alvesson & Skoldberg, 2009). Grounded theory researchers have since adopted other epistemological and ontological

positions, including constructivism, thus demonstrating the flexibility of this research approach.

As Cutcliffe (2000) recommends that researchers use predominantly one method of grounded theory, the author chose to use the guidelines provided by Charmaz (2006), which presents a version of grounded theory based on a constructivist epistemology. This epistemology argues that objective realities do not exist, but are constructed through individuals and social processes giving meaning to situations, experience and phenomena. Constructivist grounded theory assumes that multiple social realities exist and that the researcher creates the data and analysis through interaction with participants (Charmaz, 2000). Constructionists ask how something is accomplished within the world, rather than seeing it as a given. Therefore, people are studied at a particular time and place to look at how they construct their views and actions (Charmaz, 2006).

Indeed, as Blumer (1979) writes, to be able to discover or generate questions, meanings and insights, researchers need to be able to retain their knowledge and use their theoretical sensitivities. Therefore, theory does not emerge from or reflect the data, because interpretation and analysis is conducted within a pre-existing theoretical framework brought to the task by the researcher (Henwood & Pidgeon, 2003). Therefore, the resultant theory is grounded not only in the participant's experiences but also in the researcher's experiences (Mills, Bonner & Francis, 2006). The

researcher's history and its influence on the construction of theory need to be made clear via reflective memo writing (Mills et al., 2006).

2.4 History of grounded theory

Grounded theory was initially devised by Glaser and Strauss in the 1960s through analysing their own research work. At the time the majority of research was concentrating on testing and affirming theories rather than creating new ones (Charmaz, 2006), and indeed Glaser's background was in quantitative methods and theories. Together they wanted to overcome the shortcomings of their research backgrounds (Bryant & Charmaz, 2007) and create a systematic qualitative research equal to quantitative enquiry that could move beyond description to generate an explanatory framework and theory. They created a method that had a firm core of data analysis and theory construction thus rendering qualitative investigation visible, comprehensible and replicable (Charmaz, 2006).

During its early development, objectivist grounded theory provided a justification for doing qualitative research, whilst retaining a positivist slant on the process (Bryant & Charmaz, 2007). Glaser and Strauss assumed that reality could be discovered, explored and understood. Although the authors recognised that the research process should include a dialogue as well as data analyses, they did not perceive this as a central point of grounded theory (Bryant & Charmaz, 2007).

There was a change of direction however in which Glaser continued to utilise grounded theory as a method of discovery, understanding categories as emerging from data, and relied on direct and somewhat narrow empiricism (Charmaz, 2006). Strauss worked with Corbin and utilised the method for verification, which was

criticised for forcing data and analyses into preconceived categories and disregarding the theory's fundamental tenets (Charmaz, 2006).

Alongside the development of grounded theory there was an epistemological shift towards social constructivism from the late 1950s onwards (Bryant & Charmaz, 2007). This position claims that people construct their realities through their actions. This process of construction is sustained and never completed.

It was only later, after the year 2000, that Charmaz stripped the positivist mantle away from constructivist grounded theory (Bryant & Charmaz, 2007). Constructivist grounded theory occupies the middle ground between realism and postmodernism. It is realistic in trying to represent a studied phenomenon as faithfully as possible, accepting reality as multiple, subject to redefinition and indeterminate. It is interpretivist by acknowledging that data are conceptualised in some way (Bryant & Charmaz, 2007). Therefore, constructivist grounded theory creates limited and tentative generalisations and not universal statements. In this perspective, the researcher is an interpreter of the studied phenomenon rather than an authority defining it (Bryant & Charmaz, 2007). Glaser and Strauss talk about theory emerging from data separately from the observer (researcher). In Charmaz's conceptualisation of grounded theory, the theory is constructed through people's (researcher's and participant's) past and present experiences and interactions with people, perspectives and research practices (Charmaz, 2006). The researcher's background alerts them to look for certain patterns, processes and possibilities in the studied data (Charmaz, 2006).

2.5 Sampling

Grounded theory uses a theoretical sampling process embedded in ongoing data analysis (Hood, 2007). Theoretical sampling aims to provide theoretical

exploration and not confirmation; it is a tool for generating theory and not investigating cases (Dey, 2007; Morse, 2007).

In grounded theory research, the researcher continues adding participants until nothing new is being added to the ideas being explored, there is no set limit on the number of participants (Cutcliffe, 2000). This is called saturation of the data. Dey (1999) has criticised the use of this term however, and has proposed the concept of theoretical sufficiency. This refers to the stage when 'categories seem to cope adequately with new data without requiring continual extensions and modifications' (Dey, 1999, p.117).

However, it is not always possible to achieve this within a time limited piece of research such as this. Indeed, it was not possible to pursue the exploration of each category that arose from each interview or each interview schedule. Therefore, after the first set of interviews, subsequent interview schedules pursued a relatively specific line of enquiry. By the final interview, no new categories or new properties of existing categories were emerging. It could therefore be argued that the way the data was coded had led to some level of theoretical saturation or sufficiency being achieved. However, had each line of enquiry that arose during data collection and analysis been followed, new categories or properties of categories may have been found.

2.6 Memo writing

Memos provide the methodological link that allows the researcher to transform data into theory (Lempert, 2007). Through capturing processing accompanying the research process (such as coding, sorting, analysing) the patterns are discovered. Memos conceptualise data in narrative flow and help to increase data abstraction. They allow the researcher to formulate ideas, explore them and use them in building

the theory (Lempert, 2007). Any form of memo is acceptable (diagram, sentences, words), i.e. whatever helps the researcher to take account of his/her internal dialogue with him/herself and the data (Lempert, 2007).

Memo writing was essential in the analysis process, as it helped to maintain focus on the research aims whilst not becoming too restricted by it. For example, below is an example of a memo entry where I consider the process of implementing boundaries.

‘So far, participants have discussed the important role that they play in the relaxation of boundaries with service users. It seems that when service users are admitted to the unit, boundaries are implemented to help create ‘order out of chaos’, to create structure and to provide service users with predictability and routine. It is interesting to note that nurses speak of implementing the boundaries. However, I wonder if service users may be able to implement their own boundaries at all? This may be a further question to ask in order to develop themes and thus theory’.

2.7 Reflection

The reflective log enabled me to capture and consider preconceptions and biases that may impact on the research and the development of categories. Indeed, it is possible that having knowledge and experience of working in the setting may impact on my interpretations of the data, and thus the analysis and development of theory.

A reflection on prior knowledge.

The constructivist epistemology stance taken during this study required the author to consider how prior knowledge and experience may contribute to the development of the research questions, data collection and analysis. The author’s

interest in boundaries in mental health grew out of experiences of working within acute mental health services as an assistant clinical psychologist. In this setting were professionals who were trying to operationalize 'recovery', whilst taking a protective stance in order to minimise the risk of 'adverse' incidents such as self-harm and suicide, which could call their professionalism into question. This protective stance often led to professionals to be seeming to work against principles of recovery, such as helping individuals to take responsibility for their own recovery, with services carrying out basic tasks without involving the service user in decisions. The literature around encouraging services and professionals to relax boundaries (Slade, 2008), seemed to be in direct conflict with a service culture of paternalism, which requires the maintenance of strict boundaries, thus leaving professionals and services with a dilemma.

Therefore, the author had some prior knowledge and experience of the issue, but this had led to a curiosity in developing a further understanding by talking to the professionals at the heart of the issues, qualified nurses working within acute inpatient settings. Given that when to conduct the literature review is a contested issue in grounded theory (Cutcliffe, 2000), the author chose not to engage in a thorough literature review until after data collection. This meant that the author did not focus on beliefs arising from reading existing literature, allowing the research to be more exploratory.

2.8 Evaluation of the research

As this research was conducted in line with Charmaz's (2006) guidelines, her evaluation criteria, which attend to credibility, originality, resonance, and usefulness of the research were used in order to evaluate the research. These are shown in table 4.

They were considered throughout the design, undertaking, and reporting of the research.

Table 4.

Criteria for evaluating grounded theory studies

Credibility	<ul style="list-style-type: none"> • Has your research achieved an intimate familiarity with the setting or topic? • Are the data sufficient to merit your claims? Consider the range, number and depth of observations contained in the data. • Have you made systematic comparisons between observations and between categories? • Do the categories cover a wide range of empirical observations? • Are there strong logical links between the gathered data and your argument and analysis? • Has your research provided enough evidence for your claims to allow the reader to form an independent assessment – and agree with your claims?
Originality	<ul style="list-style-type: none"> • Are your categories fresh? Do they offer new insights? • Does your analysis provide a new conceptual rendering of the data? • What is the social and theoretical significance of this work? • How does your grounded theory challenge, extend, or refine current ideas, concepts, and practices?
Resonance	<ul style="list-style-type: none"> • Do the categories portray the fullness of the studied experience? • Have you revealed both liminal and unstable taken-for-granted meanings? • Have you drawn links between larger collectivities or institutions and individual lives, when the data so indicate? • Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deeper insights about their lives and worlds?
Usefulness	<ul style="list-style-type: none"> • Does your analysis offer interpretations that people can use in their every-day worlds? • Do your analytic categories suggest any generic processes? • If so, have you examined these generic processes for tacit implications? • Can the analysis spark further research in other substantive areas? • How does your work contribute to knowledge? How does it contribute to making a better world?

RESULTS

3.1 The Socially Constructed Nature of Boundaries

Defining Boundaries

Four participants were able to define the term boundaries, specifically in relation to the ward environment and with relationships on the ward:

I think they're limits that you have to put upon people, especially with regards to the ward environment. It's limits to what they can do, what they can have, to the type of relationship that you can have with, whether it's with a service user and, you know, like myself, or a HCA or whatever, or whether it's service user to service user (Laura).

In addition, whilst considering needing limits within relationships with service user, this one participant acknowledged that boundaries were also applicable to staff:

It's important to have a good working relationship but I think there's a fine line that you could step over (Ben).

The Personalised Nature of Boundaries

As outlined in the journal paper, several participants spoke about the personalised nature of boundaries, which these quotes explain:

Everyone's different. We treat everybody as individuals, everybody's different. They've all got different illnesses, different needs, different ages, different gender (Carol).

...people come from different areas, different boundaries, boundaries are different'
(Andy).

All participants spoke about boundaries developing through experiences in childhood, as illustrated here:

'Well it's your upbringing isn't it? I think it's about how you've been brought up. Certain people have certain values and beliefs that they would not, you know, and that's been taught to them. You don't do this or you can do that... I think it's about your beliefs and what's been instilled into you as a child and how you've been brought up, within broader life.' (Ben)

As boundaries were perceived to develop through early experiences, they were seen to be underpinned by values. Participants acknowledged that it was impossible not to be influenced by these values when working on the wards:

'Well I suppose from myself, I think everybody sort of grows up and learns their own personal boundaries. And you can't help but that to influence how you communicate with other people and your own value systems... So the boundaries have always been there and I think that impacts on the way that you practice...' (Trisha).

Therefore, given the different life experiences that people have, which influences the different values that participants have, it is unsurprising that the participants here recognised that people are likely to perceive boundaries differently

and implement them differently. This may go some way to explaining why participants found it so difficult to define the term boundaries.

Three nurses also applied ideas about the importance of upbringing to service users, and how this could impact on service users' perceptions of boundaries. They also connected this idea to particular presentations or diagnostic labels attached to service users, particularly 'personality disorder' and 'bipolar', e.g:

'Especially with personality disorders, you'll find they've had really bad upbringings, generally they don't have a cohesive sort of support system around them. They quite often won't have had these boundaries instilled as children, so they don't know what boundaries are, they don't know what's socially acceptable. So quite often you'll get them coming into hospital and behaving in ways that are thought to be socially unacceptable (Laura).

One participant also recognised that as service users are likely to have their own unique experiences, service users may have their own ideas about boundaries and may have different boundaries to those perceived to be important to staff.

'So we're not always, again we're working to our boundaries, we're allowing them to get on with what they want to do on the ward, without interfering with them. I mean they have their own boundaries from us as well I suppose, as us from them (Dawn).

Professional Training and Experience

Although participants perceived that childhood experiences influenced their ideas about boundaries, it was recognised that such ideas could change over time.

Specifically, participants considered training to be important for a professional conceptualisation of boundaries:

‘So you definitely, your life skills will teach you about boundaries, but also here, doing your training through University or all that kind of thing. That’s what teaches you the other boundaries that are used, yes’ (Isla).

In addition to training, post qualification work experience on the wards was also considered to continually shape ideas about boundaries:

‘...I certainly think boundaries were the main learning curve when I qualified and became a nurse and sort of respected that a lot more... So I think in terms of valuing it more and perhaps the understanding was there, able to value it and to understand the concept in that manner and to why it’s there, is certainly from sort of working within this role (Mark).

More generally, professional codes of conduct and practice were seen as important in shaping boundaries:

I think, I’ve realised that my own code of conduct and, you know, my sort of NMC registration is very important to me. So I sort of, I do sort of preserve that and try to protect that as much as I can (Mark).

Organisational policies and procedures influenced how participants perceived boundaries, and how they implemented them in practice. One participant spoke

specifically about how policies and procedures are developed in response to incidents and feedback on services:

'A lot of these things have come from lessons learnt from things that have gone wrong. So again, that's another factor with the boundaries, of things that have happened, lessons learnt from things that have not gone so well by not having boundaries in place. It would be through incident reporting, patient feedback, how they feel about things and what they'd like to see improved or better, carers' involvement. So yes, a lot of it is through, and sort of national guidelines that are put in place by NICE and things like that, they're expectations of how we do it forms around that, so it's all about governance.' (Sarah)

As well as conceptualisations of boundaries changing depending on different work experiences, the participants perceived that the setting in which they worked in could also change or influence their ideas about boundaries, as this participant outlines:

...if I went to work at a different hospital, their boundaries would be totally different than I've got. (Ben)

Participants also acknowledged that they could both influence and be influenced by colleagues, for example one participant referred to *'absorbing good practice'* (Mark). Indeed, participants spoke about being influenced by others, as well as influencing others. Management decisions about boundaries were often seen as

being set, but there was some scope for feeding back information to managers to inform such decisions:

I mean the times and doors have been set by managers, things like that are just passed down to us and then we adhere to them. I mean and at times there is also, they ask for feedback from us, so we'd get some input as well. But usually it's the managers who decide most of those things (Dawn).

Therefore, although participants acknowledged that early experiences were key in developing their ideas about boundaries, these ideas could change due to the experiences of being trained as a nurse, as well as having post qualification work experience in different settings. Their professional code of conduct also seemed to be important when working day to day on the ward.

Social Expectations

Participants acknowledged that there was a social aspect that influenced ideas about boundaries, that for instance society influences what is acceptable or appropriate, and that boundaries are needed by society in order for it to function. Specifically, participants spoke about working to the routine set out by the institution, and one participant recognised that this routine was influenced by society's expectations:

'Well society's expectations is that we all get up in the morning and we go to bed at night and not the other way around. So, you know, that is something from society...But

we do get patients that stay in bed all day and then get up at night, and then want to stay up all night because they've slept all day.' (Margaret).

3.2 The Perceived Need for Boundaries

Maintaining the Professional Relationship

As outlined in the journal paper, the professional relationship was deemed to be important for many reasons. Specifically, the boundary implemented of being held within the mental health unit, and the relationship with nurses within that, was perceived by participants to mean that service users had to spend time with nurses, so that they can focus on recovery:

'It allows them to focus on what they're actually doing, rather than chatting about, oh 'what did you do on Saturday night?', or things like that. It allows them to focus on the recovery (Jenny).

The relationship was also considered important in terms of encouraging the service users to think about life after the acute unit, which was considered to be an important part of recovery. Indeed, from some participants, there was an understanding that recovery from mental health problems is about the service user being involved, and thus the relationship was again perceived to be important in order to get their perspective on their recovery:

'I mean we spend a lot of time with them, so we get to know them quite well in a social way. I mean they do discuss a lot of their social life with us, their dreams and desires,

if you like, you know, what they want for the future. And we encourage that as well, you know, because that is always part of the recovery, to be discussing what the next move is for them, what they want to do next and moving on' (Dawn).

This conceptualisation of recovery is perhaps in contrast to the perception that other participants had that the relationship is a tool to help service users to understand their mental illness, as well as a forum for the nurse to give advice to the service user. This perhaps suggests a recovery focus that is led by professionals, rather than a recovery that is led by the service user themselves. Therefore, although some participants spoke about 'advice giving', others seemed to think that the therapeutic relationship could offer more of an opportunity for the service user to feel listened to, and to consider their recovery within this discussion with the nurse, and to offer more of a human connection.

In terms of recovery, the relationship was also seen to be important for nurses to spend time with service users, and notice potential signs of recovery, or for a sign of worsening mental illness, such as a change in a person's behaviour.

'Say they came in, they were tense, they didn't particularly make very good eye contact, they didn't want to interact. And then you saw that, well yes, they looked a bit more relaxed, they're facially not so tense, the communication is improving. It might be that they're eating more, they might be asking for things, rather than waiting to be asked' (Trisha).

Lastly, it was perceived that having a good therapeutic relationship would make it easier to implement boundaries and make them more palatable:

'Because if someone you don't know, and they don't know you, you don't know them, if you're putting boundaries in place, it could come across as like, you know, rules, they won't let, you know, you say no, it doesn't always come across that well. If you've got a better relationship with someone, it can sometimes be easier saying no'. (Andy)

However, it is interesting to note that it was also outlined by participants that boundaries are likely to remain rigid whilst getting to know service users, therefore it is unclear how this, combined with the need to have the relationship prior to implementing boundaries, takes place.

Returning to the perceived need to maintain the professional relationship, implementing boundaries within the relationship was perceived to be important by participants, given that nurses and service users spend so much time together. There was a concern that their roles could become unclear, and that service users and nurses could sometimes 'overstep' their role to become too friendly:

Mostly it happens from the service user and their approaches towards staff members or towards the fellow service users. Usually it can be where they get a bit more touchy feely, kind of invading personal space more than they did when, even when they first came in. Trying to be a lot more personable and more friendly, I guess like you would if you were sat talking to your group of friends out in the pub or, you know, whatever. They'll start having conversations more like that with you. And you have to remind them that that's not appropriate (Laura)

Participants were in fact very clear that their role was as a professional to help the service user to get better. They did not want it to be seen that they were there to

be friends with the service user, and were clear that they did not want to get into too much of a personal relationship with a service user. This involved for instance not partaking in something you might do with a friend or family member, such as:

*'You've got to have boundaries, we're professionals and we're doing a job. And boundaries, you know, it's about being professional but not getting in too much of a personal relationship. I mean you wouldn't have a relationship with a service user, they wouldn't borrow money off us, or lend a service user money, or, you know, discuss other staff members or discuss another service user with a service user. There's boundaries, you know, there's things that you don't cross and things like that'.
(Ben)*

One participant spoke in particular about an example in which the role of 'service user' had been blended with the role of staff, and outlined the negative consequences of this:

*'Because they'd been on the ward for such a long time they knew the routines. So they would, when there was a new patient coming in, they'd be very close to them, you know, kind of get to know the running of the ward. They've been in the **** Magazine and had a lot of input in that. So that was a way to try and get that patient better but it's kind of backfired a little, in the way that now they don't want to leave. They see themselves as actually being above the rest of the patients.'* (Laura)

As well as perceiving that boundaries are needed within the relationship to distinguish between being a nurse and a service user, there were also some physical boundaries that cemented this difference in role:

‘Obviously, there is the difference between being a member of staff and being a patient. Not being allowed in all areas of the ward, they’re not allowed in the office, staff room, things like that. Not being allowed to smoke on the ward, not being allowed to use the telephone all the time.’ (Kerry)

Boundaries were perceived to important within the therapeutic relationship in order to reduce professional anxiety, relating to offering physical comfort, or indeed just being friendly to service users. It was perceived that this could be misunderstood and leave nurses open to allegations:

‘But also deal with sort of delivering quite an empathetic and warm approach as well, but acknowledging that physical touch, it can, whilst serve quite importantly towards certain individuals, it’s professionally thinking about my code of conduct, which it may ensue various sort of allegations.’ (Mark)

Concern about allegations seemed to vary according to the service user who nurses were forming the relationship with, and therefore it was perceived important to spend time getting to know the service user, which would then influence the boundaries that were perceived to be needed by the nurse in the relationship. Diversity seemed to be a particular consideration:

'It's, it can be seen, obviously that could be seen as, in people's, in my eyes I wouldn't, I don't know, you just learn to put boundaries in place like that. With a little old lady, like your grandmother, and she was upset, you might put your arm round them and take them a cup of tea. A young girl that was upset, you know...I think so, yes and it's also leaving yourself open to accusations as well.' (Ben)

One participant spoke in detail about how the culture of blame seems to impact on the nurses' ability to carry out their duties, as there is a fear of allegations:

'I think people are fearful of complaints, allegations and litigation. I think we live in a culture where it's all about defensive documentation and watching your back. And it's not about positive risk taking, it's not about empowering individuals. It's very much a case of, no you mustn't do that or you mustn't say that. That has to be done in this way because if they say that and we've done that, then we're going to be in big trouble.' (Trisha)

Other participants spoke in a related vein about taking responsibility for service users, for a fear that they would be blamed if anything went wrong. For instance, this was related to suicide risk, as well as service users' belongings going missing:

'You'd be surprised how many people come in with maybe five or six hundred pounds because they've had some benefits. They've spent some money and then they've come in, they've got a load of money. Trying to get them to trust you to take it to the general office and put it in a book, sign it. They go round with us and pay it in and just leave so much in the cupboard. But again, we're so responsible for everything for

them, and it's, it always falls back on us as nurses, if anything does go wrong.'
(Margaret).

Participants were particularly concerned with protecting their professional registration. Ultimately there seemed to be a concern that an allegation could lead to the participants' conduct being called into question, therefore there seems to be a perceived pressure from an organisational level, and this seems to be a consideration in interactions:

'I think, I've realised that my own code of conduct and, you know, my sort of NMC registration is very important to me. So I sort of, I do sort of preserve that and try to protect that as much as I can. So yes, I think obviously now, being qualified for over three years, I certainly take more of a protective stance, as opposed to, you know, one in which I was a little bit more free, so to speak.' (Mark)

This participant furthers that this pressure seems to be coming from the profession by which they are trained:

'And, you know, there's all this about bringing professions into disrepute. So you have that boundary instilled upon you and then.' (Trisha)

However, there again seems to be a dilemma or conflict for nurses here, as they hope that despite having a more 'protective stance', that the care they provide is still warm and empathic:

'I'll protect my registration. But I also don't think that that sort of limits the way that I sort of provide care, you know, in an empathetic or a warm professional way. But I think certainly that I hold that in the highest regard.' (Mark)

When considering service users violating boundaries, it was interesting that although most participants were concerned about the information they shared with service users directly, one participant spoke about how she was concerned that service users might pick up on conversations between nurses about their personal lives. However, this same participant acknowledged that even though she had had conversations about her personal life at work and she was concerned service users might over hear, no service user had ever mentioned anything to her about her personal situation, as she had feared they would:

'So maybe patients don't take on as much as we think they do. So that's something else to consider that, you know, even if it's just said in passing, are they going to take that on board or are they, their mind's just so full of their own problems that they wouldn't even think about it.' (Margaret)

In summary therefore, the therapeutic relationship seems to have many functions, which reflects the different conceptualisations of recovery. The therapeutic relationship is perceived important for nurses to give advice to service users, whereas others see the relationship as getting to know the service users and working collaboratively to think about their individual notions of their recovery. There are several conflicts that nurses experience when maintaining the therapeutic relationship. There seems to be a concern amongst participants about protecting themselves from

allegations being made by service users and from boundary violations which indicated a more rigid therapeutic relationship, but there is also a perceived need to build the therapeutic relationship which entails sharing some personal information, indicating some flexibility.

Providing Structure and Control

There was an understanding from participants that mental illness was connected to a loss of boundaries, or with lacking boundaries through not having been taught them:

‘Yes, losing some of the skills or their usual personal values that they wouldn’t normally do in society and don’t live like that.’ (Sarah)

Participants perceived that there were different types of difficulties with boundaries, which corresponded to different diagnoses. This participant is speaking about boundaries and bi-polar disorder:

‘...you’ve got patients who are quite elated, they find it difficult to stick to boundaries. People who are quite high, often lack sort of boundaries, it’s like their filter gets taken away and they don’t behave in a way that society would probably view to be appropriate.’ (Laura)

There was also a perception that service users with a diagnosis of personality disorder may not have been taught about boundaries as children, so that they may not know what is acceptable within society:

'They quite often won't have had these boundaries instilled as children, so they don't know what boundaries are, they don't know what's socially acceptable.' (Laura)

Lastly, regarding psychosis, there was an understanding that perhaps a person's mind might be chaotic:

'Yes, I think if you've got, for example, say the really chaotic mind. So you're quite thought disordered, you find it very difficult to concentrate. You might have thought block, you know, so there's lots of things impacting on your ability to be able to rationalise and communicate.' (Trisha)

Given these conceptualisations of mental illness, participants perceived it was key for service users to have an external structure or routine for their recovery. In particular, participants cited having a sleep and medication routine for service users as particularly important:

'...We're not doing it because we want an easy night, we're doing it because we're trying to promote sleep, promote sleep and also recovery. It gets them back into a routine for when they leave here. Rather than, if I left that telly on, gave them tea and coffee all night, they'd sit up all night and sleep all day...They're missing their meal times, some of them not waking up for their medication, they're missing appointments. So boundaries does have an impact on people's recovery definitely. Medication is another, you know, we have times that they take their medication, there's a reason for it and you have to stick to that, as part of their recovery. And it's also getting them into a routine for when they leave hospital, to be able to take, know that, you know, I have

to take my medication at such and such a time. Because 90% of people that come back in here, is through non-compliance of medication.' (Ben)

Despite speaking of the perceived benefits to the structure and routine, the same participant spoke of the rigidity of the boundaries perhaps not being useful for recovery:

'You have your breakfast at a time or you don't get any. You have your medication at that time or you don't get it. You put down as refused, that has an impact on a person's recovery, because they put down as refuse, they're being awkward. They're not being awkward, they might not feel like getting up and taking fifteen tablets as soon as they get out of bed.' (Ben)

Participants also reported that they perceived this structure to provide service users with some reassurance that the environment is predictable, which service users appreciate:

'...there is feedback from patients that they like that as a daily routine, in times of acute, you know, mental illness. That they like to be able to predict when things are going to happen, you know, it provides some reassurance.' (Mark)

Implicit in these understandings of mental illness and treatment is a perception that recovery is about having structure and routine for when leaving hospital, and this can help service users to get in to a 'normal' way of life, indicating that perhaps it was perceived that service users were not living according to societal norms. The

perception that it is a compliance with a set structure and routine (including sleep and medication) that will lead to recovery perhaps is a narrow understanding of the concept of recovery. Generally, participants did not question whether service users might agree with this conceptualisation, and there was a perception that they should comply with the treatment:

'They're not being concordant with their medication, so we have medication at certain times, you know, they have to come to the clinic to get their medication at that time. Depending what it is, you know, I'm not saying you like blackmail people but, that's not really the word to use.' (Andy)

However, despite all participants perceiving this structure to be important for the recovery of those with a mental illness, three did perceive that the boundaries may appear *'punitive'* (Mark), *'unfair'* (Ben), and lead to a sense *'institutionalisation'* (Margaret).

Whilst participants spoke of needing to have an element of control within the environment, they also claimed to dislike the rigidity of the boundaries, seeing them as not representative of real life where there is an element of choice and freedom:

'Cigarette times are rigid. Their dinner time's rigid, they've got to have, well they missed a dinner, because that's what time the canteen is open and that's what time the food gets brought on the ward. If you were at home, I know I certainly, I like to get up in the morning and I might wait half an hour and then I'll have a cup of coffee. And then, I don't like to have my breakfast straight away, I like to be up a couple of hours, then I'll have something to eat. And then I might want to watch a certain thing on

television or go and fetch a newspaper or do this...Here, that's been taken away from you.' (Ben)

Further, there was a perception that implementing boundaries impacted on the therapeutic relationship:

'It's very difficult to form a therapeutic relationship when we think that we're locking them away and taking them away from an environment in which they feel comfortable and relaxed, which is their home'. (Mark).

Participants perceived that the boundaries they were putting in place (specifically keeping someone on the unit against their will) could impact on service users' impression of the acute unit and lead to them not engaging with mental health services in the future:

'And it will impact on their long term relationship that they'll have, whether it's coming into hospital again or whether it's actually working with their community teams. And if you put someone into this sort of a restricted environment and that's what they think, you know, mental health services is about, they're less likely to engage in the future and more likely to end up relapsing and coming into hospital.' (Laura)

This possible 'disengagement' with services was considered understandable given that the environment could be perceived as frightening, with this one participant empathising with the service user experience:

'...sometimes people are sat at home watching TV, three doctors come in with the police and take them out of the house and bring them to a strange environment. And they've got to sleep in a strange room, sometimes in a dormitory with other people you don't know. You could be, you're going to be frightened anyway. Then you might have someone in the next bed that's screaming and shouting all night. Someone over there that keeps coming into your cubicle at night. So yes, the liberty is a big boundary, it's something massive that's been taken away from someone. And you can understand people when they say, I'm not staying here, I don't want to stay here. Would you want to stay here? You'd be frightened to death, wouldn't you?' (Ben)

It was also acknowledged by participants that the same fears that service users have about acute inpatient units, may also be experienced by the wider public about coming into hospital:

'...that would be a perceived threat before coming into hospital. You know, it would be like, I'm going into hospital, I'm going to get medication. That's got to impact on them.' (Trisha)

*'...So there is that perception that ***** the local nut house, where everybody goes crackers and we're all fighting constantly.'* (Trisha)

One participant questioned the nurse's role of implementing strict boundaries, feeling that perhaps they had no right to remove part of somebody's character, however, this again presented a conflict in terms of needing to maintain the health and safety of the service users:

‘...people who like to sit in the garden and smoke all the time, that’s part of them, that’s their character. So who are we to take that away? But then again, we’ve got to look at people in general and their health...’ (Margaret)

Although participants spoke of needing to take control for service users when they were particularly unwell, there seemed to be a conflict of not wanting service users to become too dependent on the nurse or the service. Indeed, it seemed that ultimately this participant was talking about trying to move the service user to independence as part of their recovery:

‘And sometimes, you want to help them more but people need to do some stuff for themselves, you know, like level of independence. Because, you know, you could almost spoon feed people and they don’t need it. And is that helping their recovery? Because at some point they’re going to be discharged and they’re on their own...’ (Andy)

Similarly, this participant speaks about how the Mental Health Act does not encourage service users to take responsibility, and to carry out tasks that they may be capable of:

‘But I think the way that we work within it sometimes frustrates me, that people aren’t given the responsibility that they could manage, if it weren’t for the Mental Health Act. I think progress sometimes can be slowed through it...’ (Trisha)

Managing Risk and Safety

Managing risk and safety was perceived to underpin the need for all boundaries, perhaps reflecting the dominance and preoccupation of risk minimisation:

'Well yes, I think it's paramount. I mean working on an acute ward, more often than not there are a lot of physical boundaries, sort of a locked door is a boundary I suppose. Mental Health Act, legislation, that's often a boundary. Observations, they're all boundaries. So, you know, yes and they are all generally, go around risk don't they?'
(Isla)

'It's all risk assessment, assessing the risk with, you know, something happening and you try and minimise that risk.' (Andy)

There was seen to be a need to tailor the boundaries according to the assessment of risk. It was acknowledged that risk often changed, and so there was a need to assess risk regularly, if not constantly in order to tailor the boundaries:

'Yes, it's continual assessment, like not just shift to shift, it's likely to be hour by hour, more frequently if necessary, as things change, for whatever reason they might change...' (Kerry).

However, there was a recognition that despite boundaries, such as regular observations, risks could not be eliminated and assessment of service users was limited by reliance on self-report:

'Duty of care, you know, your responsibility. They come onto the ward, they are your responsibility then, for their safety and wellbeing, and that of everyone else. So if I'm, for a patient like that, if I was going to look at the observation levels and reduce that, I would speak to the other nurses, then I would go and speak to the patient. If they can tell me that they're fine, but they might just be telling you they're fine because they want the observations to reduce, so they've got the opportunity to go and say harm themselves.' (Andy).

The above quote also illustrates the sense of responsibility that nurses feel they have in relation to maintaining the safety of service users and minimising risk. A preoccupation with this may be linked to earlier accounts of a concern of being blamed if there was an untoward incident (Trisha).

There was also a concern that care might seem cold due to a focus on risk, perhaps highlighting a conflict in which nurses have to balance the roles of both carer and custodian:

'...because we're here to provide a caring approach to people and a level of care that hopefully is warm and empathetic. But sometimes it may seem quite cold because we're taking a very abrupt stance of perhaps the most restricted approach by locking somebody away.' (Andy)

This participant acknowledges the power imbalance between service users and professionals, however, in the same quote there is a clear conflict revealed that despite this, the safety of the unit is paramount:

'I think it's difficult sometimes to maintain a comfortable balance. I think, for example, when we have people here who are very violent, I think it's easy to forget the power differential and get sucked in and drawn into the fact that that person is violent. Yes, that is a real issue, it's a real issue for lots of reasons and we have to maintain safety of ourselves and others, because we're not just there for that person. We've got to see the whole unit safe.' (Trisha)

3.3 Enacting Boundaries

Dilemmas about Drawing the Line

As noted in the descriptive theme of *'maintaining the professional relationship'* it seems to be a challenge for nurses to maintain their professional role, whilst building a therapeutic relationship. This category expands further on this challenge, considering how much sharing of personal information nurses perceive to be appropriate.

Although some self-disclosure seems to be important within the relationship, there seems to be something about not sharing too much detail. In particular, although this participant describes wanting to come across as a friend, there is a limit in terms of not wanting to have a relationship outside of the professional context:

'But just talking to them as a human being, as one person to another, not as a member of staff, you're speaking to them more on, what we say is we develop a therapeutic relationship. I mean in some, that way you're coming across as a friend, but a friend, not a personal friend, do you know what I mean? Not a friend as in you would have

and go out with them and be at home and things like that. But they can look on you as a type of friend, as someone they can trust, someone they can turn to.' (Dawn)

Not sharing too much information relates to a concern expressed earlier about being concerned that service users might violate a nurse's boundaries:

'...And you don't know if you may rub them (service users) up the wrong way when they're in here. And they may well, if they found you outside of this environment, especially if they were unwell, there's nothing to stop them from approaching you in a not very nice manner.' (Laura)

It was acknowledged by participants how close service users can feel to nurses, particularly when they have been an inpatient for a long time. This could create a dilemma for the nurse in ensuring that the service user feels cared for whilst maintaining the professional role, but not kept at a distance by the nurse:

'..But I think we are always under the understanding that this is a patient, they are going to go home, so we have to be very careful how far we do take that relationship. We just try hard to keep, it is hard though sometimes, to keep them at arm's bay, without you feeling that you're pushing them away. And you don't want to give them that feeling as well.' (Dawn)

For some participants, there was a perception that nurses who had been qualified a long time may be more relaxed with service users as they had perhaps developed a relationship over many years, which seems to influence how rigidly they hold relational boundaries when a service user is admitted onto the ward:

'I mean a lot of the patients, they're patients that we've known, that I have known for nearly all these twenty years. So with those people, I do feel a lot more comfortable than say somebody who's just come in, and then you get to know them and get to know their needs, I suppose, or if there's any risks or safety issues involved.' (Dawn)

Service User Reaction to Boundaries

Participants spoke of service users reactions to boundaries changing over time. It seems to be that as mental health is seen to improve, that service users realise that they did in fact need to have boundaries in place when previously they had disagreed with them. Participants perceive that it is due to mental illness that the service users react aggressively and that if they were well they would not behave in these ways:

'Then later on when they realise, if they've been particularly psychotic or whatever, then later on when things stabilise more and they either remember or things come back to them, what's happened, it can be quite upsetting. Because then the truth, particularly if they've been violent or aggressive or they've done something to themselves that they wouldn't normally dream of doing, totally out of character or anything. They might have done things embarrassing or something, it can be quite devastating at times.' (Kerry)

The above quote also illustrates the participant's reactions to the service user when it is perceived they are mentally unwell, which can be experienced as distressing.

Tailoring the Boundaries

Although participants spoke of diversity being very important to bear in mind when tailoring the boundaries, diversity also seemed to create some boundaries, or barriers to care:

'Yes sure. I mean we often have to work within, if there's a non- English speaking person on the ward, we often have, have to include sort of interpreters within the care that we deliver. And, obviously, the interpreters can't be there twenty four hours, seven days, and that's quite detrimental to the care. And that produces boundaries, both on sort of our ability to interact on an emotional level and to provide that empathetic level of care and a warm approach.' (Mark)

Although diversity could create boundaries or barriers to care, several participants spoke of being able to use difference and diversity to their advantage when providing care:

'And he sees it more as confrontational and authority from a male telling them what to do, rather than a female, they might come across more, almost like more mothering I suppose in some ways, and they'll accept that...But, you know, if you know that with a patient you can use it to your advantage I suppose. Not making it sound bad or anything but if it's going to get the desired outcome, it's going to make sure it's a safe environment for everyone, you know, it's a good tool to use I suppose.' (Andy)

However, there were apparent conflicts from the participants who spoke of perceiving it to be important to tailor the boundaries, but who acknowledged that this could be difficult given that people perceive boundaries differently.

'There's a dilemma and also, everyone works differently. So one, somebody might not agree with, another nurse may agree with or they may say a patient can do this. And I might be thinking, oh no, no, they shouldn't be doing that.' (Andy).

This could lead to problems on the ward if staff then went on to implement the boundaries differently, and go against the decision made on a previous shift:

'Because it's no good me coming on shift and saying, no don't worry about that, you can have a fag, you know, two fags, don't worry about it. And then the next person coming on and not sticking to that. Because then it's, I'm the good cop, they're the bad cop.' (Ben).

This was referred to as creating splits within the team, and the above quote indicates that it was the behaviour of staff that could create these divides within the team, therefore explaining the need for consistency. However, others saw it as manipulation on behalf of the service user:

'...they need to have everything really tight, so that, you know, they know where they stand and they don't try and manipulate staff, because that happens a lot. Staff splitting, attempts at playing staff off against each other, that's a certain diagnosis that is quite common with, that we have to put boundaries in place...' (Sarah).

However, whilst differences in the way team members perceive boundaries and implement them could be seen as creating problems on the ward, others saw it as beneficial, in terms of being able to match team members to service users that they get on with:

'Well I think that as a team, because we're all different, that's why it works. Because if we were all the same, then it wouldn't, as a team, on this ward we're quite a good team as well I think. And with different patients, we'll work between us, who works better with different patients. And if like certain patients work better with certain staff, we kind of follow that, and the other way round. Because like I may be better with one person but not with another, and somebody else might be the opposite, so we try and work it for the patient's interest.' (Kerry)

However, although participants saw it as important to be consistent with the boundaries, many also spoke of boundaries needing to be of therapeutic benefit. This meant that sometimes participants perceived it to be important to actually not stick to boundaries that were usually perceived important to maintain structure and routine on the ward, such as smoking times:

'So I might make recommendations about a patient, say if they've been wanting to go for excess cigarettes, I might say, we've stopped them, it's every hour on the hour. Throughout my shift that patient might be, you know, agitated, wound up, aggressive. The next shift comes on, they may think, well do we want to be battling with this patient all the time? So they might just relax that off a bit and just let them go off for a cigarette when they want.' (Andy)

However, the above quote also implies that relaxing off a boundary is more to do with staff benefit than of being of benefit to the service user.

Therefore, there seems to be a conflict for participants. It is perceived important for them to tailor boundaries to the individual service user, however, there is an acknowledgement that staff members are also different and are likely to perceive boundaries differently which can lead to differences in the implementation of boundaries. This can create problems on the wards, with staff becoming 'split'. However, differences can also be seen to be of benefit, in terms of matching a nurse to a service user who they get on with, perhaps highlighting the perceived importance of the therapeutic relationship.

DISCUSSION

4.1: Further Discussion on Social Constructionism

When using a social construction epistemology, the goal is to understand the world and the lived experience of from the perspective of those who live in it. Social constructionists view reality as socially defined, but this reality refers to the subjective experience of everyday life and how the world is understood, rather than the objective reality of the natural world (Andrews, 2012). One of the main criticisms of social constructionism can be summarised by its perceived conceptualisation of realism and relativism. These represent two polarised perspectives on a continuum between objective reality and multiple realities. However, both can be problematic for qualitative research. This is because the realist position can be seen to ignore the way that the researcher constructs interpretations of the findings and assumes that what is reported is a true interpretation of a knowable and independent reality. However, relativism can conclude that nothing can ever be known for definite, that there are multiple realities

with none having precedence over the other in terms of claims to represent the truth about social phenomena. However, as Berger and Luckman (1991) outline, social constructionism does not make ontological claims, looking just at the social construction of knowledge. An example to illustrate this by Andrews (2012) is the idea that disease can and does exist as an independent reality. This is consistent with the social constructionist view. However, the naming of disease and what constitutes disease is arguably a different matter. This has potential to be socially constructed. This is not the same as claiming it has no independent existence beyond language (Andrews, 2012).

However, if there is no one reality, it is interesting to consider how we can change things based on the findings of our research. Hamersley (1992) questions the usefulness of findings generated from studies using a stance of social constructionism, given that the number of accounts that can claim legitimacy. Conclusions and recommendations of research could be seen to constitute just another account (Murphy, Dingwall, Greatbatch, & Parker, 1998). However, reassuringly, Andrews (2012) points out that social constructionists set out to have their findings accepted by presenting a convincing argument rather than arguing that their results are definitive. Therefore, research conducted from this epistemological stance can generate debate and lead to change.

4.2 Further Implications for Practice and Research

Reflective practice spaces can be used to validate strong emotions inevitably generated in the acute setting. As MacCallum (2002) outlines, the process of othering may be used as a way of avoiding the distress associated with this work, creating a boundary between the self and 'other' to avoid the distress. It can enable concerns to

be voiced in a constructive context, and can facilitate the emergence of constructive solutions from within the staff group. This can be a supportive environment with a focus from learning from experience. In The New Ways of Working Document for Applied Psychologists (British Psychological Society, 2007), as well as the more recent guidelines 'Commissioning and Delivering Clinical Psychology in Acute Adult Mental Health Care' (BPS, 2012), this is described as being a forum in which the staff team can be helped to understand the level of intensity in the interactions between staff and service users, and the importance of the therapeutic relationship. This may highlight psychological processes such as being an in-group or out-group, such as stigma and othering. It is important for ward staff to have a space to reflect on how this often difficult environment on individuals and their practice.

Psychological formulations are a tool used by clinicians to relate theory to practice (Butler, 1998). Clinical psychologists working within the acute inpatient setting can offer a valuable way of understanding a person's problems that provides an alternative to the not only the psychiatric diagnosis, but also an alternative to the understanding that mental illness is a result of a loss, or of not having learned about boundaries. Not only would this help to broaden understandings, the process of formulation can also consider the broader context in which the individual service user is situated, that is in the context of a dilemma between recovery oriented practice and concern about risk minimisation. Indeed, where the systemic perspective is ignored, the service is can be drawn into similar patterns of responding to risk. Formulations that ignore this context may fall short, and thinking about a person's recovery can be meaningless to them

Indeed, participants here were shown to have a narrow conceptualisation of recovery, in which there was a guise of collaboration up to a point, but that service

were required to agree with and stick to boundaries prescribed by others. This was particularly evident when nurses were concerned about risk, or when there were legal boundaries, that is the Mental Health Act involved. This perhaps illustrates the power of the discourse of risk minimisation, of the perception that service users are not behaving to societal norms and so need to be controlled. Therefore, despite service users calling for a relaxation of boundaries, or a less rigid approach, there perhaps are other, more dominant discourses that take precedence over theirs. The narrow understanding of recovery also reflects the definitions that participants held about mental health that recovery is about re-implementing boundaries.

Although this research has looked at the perceptions of nurses regarding boundaries, in doing this it has neglected the service users who these perceptions are likely to impact upon. It will be interesting to conduct further research looking at how service users experience care within the specific dilemmas regarding the perceptions of boundaries. Research already indicates that service users value relationships with professionals that promote collaboration and risk taking (Cleary & Dowling, 2009). This therefore suggests a relaxation of the professional role to allow the service user more independence and responsibility. However, looking at how this relates specifically to boundaries for service users is important. Indeed, although boundaries are important within this setting for mental health nurses, it may not be recognised in the same way, or given the same importance by service users. It will be interesting to explore how they conceptualise the term boundaries, and if they conceptualise mental illness in a similar way to mental health nurses. Participants within this study saw the loss of boundaries as key in the development of mental health problems, but this may not be how service users understand the development of mental illness. The participants'

conceptualisation may be a narrow understanding and further research here could help to broaden it to encompass alternative explanations.

It is unclear if service users are even aware of the dilemmas that nurses working in the acute inpatient setting face within their work, and whether they perceive that such dilemmas impact on their experience of care. It will be interesting to see if service users experience the boundaries that are used by professionals, with the perception of aiding recovery and keeping them safe, differently to how nurses intend them to be experienced?

4.3 A Further Discussion of Grounded Theory Methodology

Some have criticised qualitative research for having a lack of direction (for instance Thomas & James, 2006), and therefore grounded theory methods have been praised for offering a set of procedures which can make it accessible, as it has a thoroughly explained method. However, it has also been criticised for oversimplifying complex meanings and interrelationships within the data, constraining analysis by putting procedure before interpretation (Layder, 1993). By doing this, it could be seen to highlight the immediately apparent, at the expense of missing more nuanced data and meaning within social situations (Layder, 1993). Further, Robrecht (1995) outlines that the sampling features divert attention away from the collected towards procedures for looking for further data. She asserts that instead researchers should extend the natural analytic process of everyday thinking by examining different concepts that might be used to summarise events. However, it could be seen that by searching for other concepts, again the researcher is being diverted away from the data, and not grounding theory in the data itself.

Thomas and James (2006) assert that the emphasis on order and procedure may impose a certain kind of 'shape' onto the data which perhaps marginalises the original voice of the research participant, implying the dismissal of the importance of people's accounts. They therefore consider that grounded theory may lead to a 'sanitised', in the name of transparency. However, as acknowledged earlier, grounded theory does provide procedural rules, providing direction for the researcher.

4.4 A Further Discussion of Limitations

Within the version of grounded theory utilised in this research, previous knowledge, biases and assumptions of the researcher are acknowledged as it can be impossible to separate out from these and be objective in the research process (Charmaz, 2006). However, this may mean that the researcher may be led by their own interests when considering further questions to ask in the interviews, neglecting other information that may be relevant. In addition, when conducting the data analysis, some themes may be prioritised whilst neglecting others. However, the data analyses were made as transparent as possible within this study by keeping a reflective diary. Although the data analyses were shared with a supervisor it is equally possible that they may have been led by their own assumptions and interests when directing the research

When conducting the interviews, the influence of the researcher as an external person to the organisation and who the participants were unfamiliar impacted on what the participants were willing to share with the researcher. Indeed, a degree of censoring when giving personal perspectives may be inherent within qualitative research. However, given the detailed accounts that participants gave to the researcher perhaps this was not the case.

Although efforts were made to provide a confidential space for participants to be interviewed in, it was interesting to note that participants were unwilling to leave the ward on which they were working for the duration of the interview. However, the interviews were still conducted within a private room on the ward. Indeed, within the interviews, sometimes there were interruptions, and understandably participants were paying attention to occurrences on the ward. Perhaps therefore this effected the narrative that participants gave to the researcher, and given that the interviews were conducted on the ward, participants may have censored the information as they were aware of the close proximity of service users and other staff members.

4.5 A Reflection on the Research Process

Conducting a grounded theory study utilising a social constructionist epistemology was an unfamiliar experience, as my only research experience is in conducting quantitative research using statistical analyses. Throughout the time of conducting the research, I was anxious about whether I was 'getting it right' and doing justice to the voices of the research participants. However, I found two things particularly useful about the grounded theory methodology and the social constructionist perspective. Firstly, the guidelines provided by Charmaz (2006), the so called 'procedural rules', actually provided reassurance and clarity to the process. Secondly, the social constructionist perspective provided a novel experience of not just considering there to be one truth that had to be found, that is the truth of the research participants. Thus it reduced my anxiety about having to find the correct answer to the research question. I was able to recognise that there are multiple realities to be considered, with no one truth to be found and privileged.

However, given my personal experience and knowledge of working on acute inpatient units, I was aware of the many tasks that mental health nurses have to complete, and the multiple stakeholders who they have to meet the needs of. I therefore felt, at times, that I had to convey this within my research, 'taking their side'. However, through supervision and keeping a reflective diary, I was able to realise that this was not the point of my research, to privilege just this group of people, but to consider the importance as well of how my the findings might impact on service users too.

As I was concerned about how my own biases might impact on the analyses, I found it encouraging that Charmaz (2006) does acknowledge that these will have an impact on the data collection and analyses process. I therefore felt less constrained by my anxieties that I would be unable to create an objective voice for the data. Whilst I found the guidelines provided by Charmaz (2006) reassuring, I was still concerned that I was not applying the guidelines correctly, and that I may be missing important steps in the research process. Indeed, this was certainly the case when I submitted the research initially, and where I had failed to move beyond descriptive categories.

I have found the findings of this research illuminating in that I had previously not considered how boundaries could be conceptualised in so many different ways and how they could impact on practice. For instance, that they could be perceived to impact on mental health, to provide relational security and to prevent risky behaviours. I had also not considered how the concept of boundaries may change depending on the context within which people find themselves, and the experiences that people have. In terms of reflecting on and changing my own practice, although not currently working within the acute inpatient setting, I am now considering the concept of boundaries within relationships more explicitly. Although I have had a fairly fixed view

on what a therapeutic relationship should look like, in terms of not for instance self-disclosing information, I think it is important to recognise that this is only one perception of how boundaries operate in relationships. Clients are likely to have had other experiences within their relationships, and so might find this style of working punitive. Indeed, there are likely to be other realities of what relationships and boundaries within them look like to others, which I would like to become more aware of in my practice.

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APPENDICES

Appendix A: Approval from the University of Lincoln



08-1-2013

Dear **Amy
Richardson,**

The Research Ethics Committee of the School of Psychology would like to inform you that your proposal **'Nurses' Perceptions of Boundaries with Service Users in Acute Psychiatric Settings: A Grounded Theory Study'** is

- ☒ **approved**
- ☐ **approved subject to the following conditions:**
- ☐ **invited for resubmission, taking into account the following issues:**
- ☐ **is rejected. An appeal can be made to the Faculty Ethics Committee against this decision (cawalker@lincoln.ac.uk).**
- ☐ **is referred to the Faculty Ethics Committee. You will automatically be contacted by the chair of the Faculty Ethics Committee about further procedures.**

Yours sincerely,

A handwritten signature in blue ink that reads 'Patrick Bourke'.

Patrick Bourke, PhD

Chair of the Ethics
Committee School
of Psychology
University of
Lincoln
Brayford Campus
telephone: +44 (0)1522 886140

Appendix B: Approval from the NHS trust

positive

Nottinghamshire Healthcare 
NHS Trust

Positive about integrated healthcare

Research Management and Development Department
Institute of Mental Health
University of Nottingham Innovation Park
Triumph Road
Nottingham
NG7 2TU

E-mail: emma.pearson@nottshc.nhs.uk
Direct Line: 0115 748 4320

Date of letter: 23/04/2013

Miss Amy Richardson
Lincolnshire Partnership NHS Foundation Trust
1st Floor, Bridge House
University of Lincoln
Brayford Pool
Lincoln
LN6 7TS

Dear Miss Richardson

Study Title: Nurses perceptions of relationship boundaries with service users

Local Collaborator: Lisa Ball

Chief Investigator: Amy Richardson (Student)

Site: Millbrook

Recruitment target: 15

Summary: The aim of this study is to explore registered Mental Health Nurses (RMN) perceptions of making, maintaining and violating relationship boundaries with service users within acute inpatient settings. RMN will be contacted via the local collaborator and invited to take part in the study, they will be given an invitation letter, participant information sheet and a reply slip. Should they wish to take part they are encouraged to return the reply slip in the stamped envelope or email the researcher.

Thank you for submitting your project to the Nottinghamshire Healthcare NHS Trust's R&D Department. The project has now been given NHS permission for research on behalf of:

Dr Peter Miller: R & D Lead, on behalf of Nottinghamshire Healthcare NHS Trust

Although NHS permission for research has been given for this study it does not guarantee that independent contractors such as GPs, dentists, optometrists and community pharmacists will be able to take part in your study.

NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation.

The Resource, Duncan Macmillan House, Porchester Road, Nottingham NG3 6AA
Chair: Dean Fathers, Chief Executive: Professor Mike Cooke CBE



Appendix C: Invitation Letter

Version 2 (17.09.2012)



UNIVERSITY OF
LINCOLN

Dear Sir/Madam

My name is Amy Richardson and I am currently undertaking a Doctorate in Clinical Psychology at the Universities of Nottingham and Lincoln.

As part of my doctorate, I would like to explore Registered Mental Health Nurses' perceptions of boundaries within relationships with service users who are inpatients in acute psychiatric units.

I would be grateful if you could look over the enclosed information sheet which contains further information about the study, as well as what to do if you would like to take part. If you do decide to take part, an interview will be arranged at a time and place convenient to you.

Please do not hesitate to contact me if you have any questions relating to the study, by using the contact details below.

Yours Faithfully

Amy Richardson
Trainee Clinical Psychologist

Supervised by Dr. Anna Tickle
Clinical Psychologist

Researcher Details:
Amy Richardson
Doctorate in Clinical Psychology
University of Lincoln
Faculty of Health, Life and Social Sciences
1st Floor, Bridge House
Brayford Pool
LINCOLN
LN6 7TS
Email: 11235863@students.lincoln.ac.uk
Tel no: 07568 072376

Version 2 (dated 17/09/2012)



Title: Nurses' Perceptions of Relationship Boundaries in Acute Psychiatric Settings: A Grounded Theory Study

Researcher: Amy Richardson

Supervisor: Dr. Anna Tickle

You are being invited to take part in a study. Before you decide whether to give your details so that the researcher can contact you, it is important for you to understand why this study is being done and what it will involve. Please take time to read the following information carefully. You may wish to discuss it with other people. Please do not hesitate to ask if there is anything that is not clear or if you would like more information. Take time to decide whether you would like to be contacted by the researcher.

What is the purpose of the study?

The aim of the study is to try to understand what important factors impact upon nurses' perceptions of boundaries in relationships with service users, who are inpatients in acute psychiatric units. It is hoped that this can help professionals and services users to have a mutual understanding about what is helpful in relationships, which may in turn help people in their recovery from mental health problems.

Why have I been chosen?

The researcher would like to interview people who are currently working as Registered Mental Health Nurses (RMNs), on acute psychiatric inpatient units, and have direct contact with service users who are inpatients.

What will I have to do?

If you are interested in taking part, fill in your details on the last page of this information sheet and send it to Amy Richardson (address below, envelope attached). The researcher will contact you to talk about the study and answer any questions you may have.

You will then be contacted to arrange an individual interview with the researcher which will last approximately one hour. The interview will be arranged at a time and place convenient to you. This interview will last approximately one hour and will be audio recorded. You will also be asked to sign a consent form prior to the interview. The interview will focus on your perceptions of boundaries within relationships that you have with service users on an acute psychiatric inpatient ward.

Do I have to take part?

You do not have to take part if you do not want to. The choice is entirely yours. If you decide not to take part you will have no further contact with the study. If you do decide to take part but later change your mind, you can withdraw from the interview and study

at any time without having to give a reason. You can withdraw up to 72 hours after the interview, in which case any data you have provided will be destroyed. If you decide to withdraw, please contact the researcher as soon as possible. After 72 hours, it will not be possible to withdraw your data from the study as your data will have been transcribed and its removal will affect data analysis.

What are the possible disadvantages and risks of participating?

There are no known risks associated with taking part in this study. However, if you feel uncomfortable answering any question, you are free to suggest we move on, or withdraw from the study altogether. Also, if the interviewer thinks that the interview is causing distress, she will stop the interview. At the end of the interview the interviewer will ask you if you feel distressed in any way, such that find difficult to cope with. If this is the case, she can point you towards appropriate support.

What are the possible advantages of participating?

The study will hopefully give us a better understanding of boundaries in relationships with service users. This will contribute to the development of good practice for service users within acute psychiatric services.

What if I have a complaint about how I have been treated as part of the study?

If you wish to complain about any aspect of how you have been approached or treated during the course of this study, you can contact the chief researcher or supervisor, details of which are given at the end of this information sheet.

Will the information I give be confidential?

Yes. The information you give will be treated in strict confidence, unless you report that there is a risk of harm to yourself or someone else, or there is a concern about safeguarding adult or child issues. In this case third parties and supporting agencies may be contacted. To ensure confidentiality, the interview data you provide will only be identifiable by a unique identification number. Some of the things you say may be used as quotations but the source of the quotation will remain anonymous.

What will happen to the results of the study?

The results of the study will be submitted as a thesis for a doctorate in clinical psychology. The findings may be published in a peer-reviewed journal and may also be presented at professional conferences. No individuals will be named in the report. If you like, you can ask to be sent a copy of the report when it is published. We can also send you a summary of the results when it is finished if you wish.

Who has reviewed the study?

The University of Lincoln Ethics Committee and the Research and Development department of Nottinghamshire Healthcare NHS Trust.

Who is organising and funding the study?

The Psychology Department at the University of Lincoln will be organising and funding this research study.

What do I do now?

If you have any questions regarding the information or would like more information before providing your contact details then please do not hesitate to contact me on the

details below. If you would like to take part, please fill in your details on the last page of this information sheet and send it to Amy Richardson (address at the bottom of the page), in the supplied envelope.

If you are able to take part the researcher will contact you to discuss the study in more detail, ask you to sign a consent form and arrange a date and time for the interview.

Thank you for your time.

Researcher Details:
Amy Richardson
Doctorate in Clinical Psychology
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1st Floor, Bridge House
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Chair of Ethics Committee:
Patrick Bourke PhD.
Chair, School of Psychology Research Ethics Committee,
University of Lincoln
Brayford Pool
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Email: PBourke@post01.lincoln.ac.uk
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Appendix E: Participant Consent Form

Participant ID Number.....



UNIVERSITY OF
LINCOLN

**Title: Nurses' Perceptions of Relationship Boundaries in Acute Psychiatric
Settings: A Grounded Theory Study**

Researcher: Amy Richardson

Please take time to read the 'Participant Information Sheet' you have been given and ask any questions you need to. Please read the following statements and initial the adjacent boxes if you agree with them.

I have read and understand the 'Participant Information Sheet', dated 17/09/2012, and have asked any questions, which have been answered to my satisfaction.

☐

I give permission for the interview for the interview to be audio recorded.

☐

I understand that all information given by me or about me will be anonymised.

☐

I agree to take part in the study

☐

Name of participant:

Date:

Signature of participant:

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Name of researcher:

Date:

Signature of researcher:

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Optional:

Would you like to receive information regarding the findings of the study following its completion in October 2013? If so the researcher will need to retain your contact details. Please tick 'yes' if you would like to receive this, or 'no' if you would rather not.

Yes please

☐

No thank you

☐

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Title: Nurses' Perceptions of Relationship Boundaries in Acute Psychiatric Settings: A Grounded Theory Study

Researcher: Amy Richardson

You are being invited to take part in a study. Before you decide whether you would like more information it is important for you to understand why this study is being done and what it will involve. Please take time to read the following information carefully. You may wish to discuss it with other people. Please do not hesitate to ask if there is anything that is not clear or you would like more information.

You may request to be contacted by the researcher by filling in the tear off slip below. However, you can contact the chief investigator, Amy Richardson directly to express an interest by emailing 11235863@students.lincoln.ac.uk.

I have read the Participant Information Sheet and asked any questions I feel I need to.
[]

I would like the researcher to contact me with regards to taking part in the research. []

Your name:

Telephone number (including area code):

E-mail address

Please send this page to Amy Richardson (University of Lincoln) in the envelope provided.

Appendix G: An Example of a Transcript, Initial and Focused Coding

Transcript	Initial Codes	Focussed Codes
<p>Q: So we're going to have a chat about boundaries in relationships. So just to start off with, what do you view as boundaries, what do you think they are? And you can think really broadly or within relationships.</p> <p>A: It's not necessarily just in the ward environment then?</p> <p>Q: No, whatever you think.</p> <p>A: I think boundaries can be very personal, to what one person likes as a boundary, another person would say, no, I mean like invading personal space or touching or hugging. I am one, I don't mind if, you know, if people are in need of a hug I'll give them a hug, people I know, whether it be patients or staff or friends and family. And boundaries are put into place as well I think for risks, you know, to alleviate risks that people perceive maybe are there, maybe evident, to keep people safe.</p> <p>Boundaries are just to, they help maintain, let me think, security for people, people know where they are when there's boundaries in place. They know, the rules, you know, oh we can't break that rule, we</p>	<p>Seeing boundaries differently to others</p> <p>Giving people a hug if they need it (patients)</p> <p>Boundaries to alleviate risk/keep people safe</p> <p>Boundaries maintain people's sense of security. 'Knowing where they are'.</p> <p>Boundaries stopping people breaking rules.</p>	<p>Having different views to others</p> <p>Physical relationship providing comfort</p> <p>Purpose of boundaries (maintain safety)</p> <p>Boundaries as providing structure and predictability</p> <p>Providing reassurance to Sus</p>

<p>can't break this rule because these are the boundaries that are in place. So they offer people security as well.</p> <p>Q: Yes, that's, I guess that's really important, that security. Do you think that offers people a sense of sort of safety?</p> <p>A: Yes I think it does overall, yes. I think more than anything, especially, you know, in our hospital environment, it is that sense of security for patients, for staff. They know where they stand with certain things and what should happen, and they can't overstep those boundaries, because if we do then there could be consequences.</p> <p>Q: It sounds like there's sort of boundaries, physical boundaries, so the touch?</p> <p>A: Yes and, as I say, I think they are more personal boundaries as well, to what one person, how they feel.</p> <p>Q: So they sort of change?</p> <p>A: Yes.</p>	<p>Boundaries offering people safety, staff and patients.</p> <p>Boundaries providing predictability – knowing what will happen</p> <p>Consequences for overstepping boundaries for patients – stopping patients doing things</p> <p>Recognising personal boundaries</p> <p>Boundaries changing depending on the person – staff and patient</p>	<p>Providing reassurance to staff and Sus</p> <p>Boundaries as providing structure and predictability</p> <p>Having different views to others</p> <p>Tailoring the boundaries to the SU</p>
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<p>Q: And I'm wondering about other physical boundaries, in terms of the ward really, like the building and the doors and?</p> <p>A: Yes.</p> <p>Q: I just wondered if you had any thoughts about that really?</p> <p>A: Well there is the boundaries as to where people can go, where it's appropriate for people to go. And again, it is about safety and security at the end of the day. We have the doors that have to be opened by staff. So patients are secure, in the sense that, they are safe on the ward, they can't get off without staff saying they can go off, and it keeps people off as well, so secure from both sides, you know. We don't get people on that we don't want coming onto the wards.</p> <p>There's security in, we've got the single rooms as well, so people aren't in a dormitory. So they're not having to share toilets and that with male or females, you know, they've got their own toilets.</p> <p>Q: So something about gender I suppose?</p>	<p>Boundaries for where people can access – for safety and security</p> <p>Locked doors</p> <p>Locked doors – staff holding the key</p> <p>Locked doors – keeping people safe in the inside and keeping people out.</p> <p>Space boundaries – not sharing dorms</p> <p>Gender boundaries – not sharing toilets</p> <p>Gender creating boundaries/boundaries around gender</p>	<p>Physical environmental boundaries to manage risk.</p> <p>Diversity influencing boundaries</p>
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<p>A: Yes it is, yes.</p> <p>Q: I hadn't really thought about</p> <p>A: Yes, so there is that as well.</p> <p>Q: I hadn't thought about as well the keeping people out for safety as well. I hadn't thought about the other side.</p> <p>A: No, that's it. I mean we do get, we do often, well not often, but we do sometimes get people, you know, trying to force their way in. And it also gives them, you know, the patients on the ward, a sense of security. Because a lot of them come and they're quite paranoid at times and they feel that people are after them. But having the locked doors, the controlled access that we have, it makes them feel safe as well. That they know that they're safe here, that people can't get in, you know, without staff being alerted to it.</p> <p>Q: Yes and also, something about keeping people in for their safety.</p> <p>A: Yes.</p> <p>Q: Does the sort of physical boundaries, because it sounds like that's really important</p>	<p>Trying to keep people off the ward</p> <p>Doors providing a sense of security</p> <p>Locked doors helping paranoid patients</p> <p>Doors providing safety</p> <p>Keeping people inside for their safety</p>	<p>Physical environmental boundaries to manage risk</p> <p>Physical environmental boundaries providing Sus with reassurance and sense of safety</p> <p>Physical environmental boundaries to manage risk</p>
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<p>for safety, is it ever a bad thing do you think, is there ever a negative to it?</p> <p>A: As in the way, a physical boundary as in the way of touch or?</p> <p>Q: I'm thinking actually more the front door.</p> <p>A: Oh the front, the doors?</p> <p>Q: Yes, it actually providing safety but is there ever a negative?</p> <p>A: There is a negative as well because again, if a person's paranoid, they're being kept in here, they think they're in prison. So there is a negative in that with some respects. But on the whole, I think people find it is beneficial.</p> <p>Q: Just thinking about boundaries again, have your views about boundaries, do you think they've changed over time? And again, you can think really broadly, and service user's relationships, do you think they've changed?</p> <p>A: In some ways I suppose they have changed. I always used to work on an open ward, where we didn't have controlled access, and patients could come and go.</p>	<p>Paranoid patients believing they're in prison – held against their will</p> <p>Views on boundaries changing depending on the environment working in</p> <p>Thinking differently about boundaries</p>	<p>SU reaction to boundaries</p> <p>Being influenced by the specific setting</p> <p>Boundaries shaped by current culture of healthcare. Being more aware of boundaries as beneficial</p> <p>Boundaries shaped by current culture of healthcare.</p>
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<p>And now we're on a ward with controlled access, it does make you think of boundaries a little bit differently. So I suppose, yes they have changed to some degree, but I think for the better, you know, we're more aware of boundaries and what's acceptable and what isn't acceptable boundaries.</p> <p>I think it's just becoming more aware of them as the time has gone on and things have changed, you know. I mean the whole unit's changed in the last few years.</p> <p>Q: So it sounds like before it's more open and boundaries weren't as stringent?</p> <p>A: No, no.</p> <p>Q: They've become more?</p> <p>A: They have and I think it's circumstances that has made it become more, you know, we have more boundaries than there used to be. We used to have smoke rooms, so people could smoke all day and every day. But now we have to put in boundaries for people who are escorted off the wards for, they have to have boundaries for the smoke times. Because I mean otherwise we'd have to have staff</p>	<p>Becoming more aware of boundaries – acceptable and what isn't</p> <p>Becoming more aware of boundaries as things have changed/unit changing</p> <p>Increasing boundaries as circumstances change Smoking changing</p> <p>Boundaries for smoke times for escorted patients</p>	<p>Being influenced by the specific setting</p> <p>Being influenced by changes in society (eg smoking)</p>
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<p>stood outside with them all day, which isn't really feasible, you know.</p> <p>Q: So there's boundaries around the times?</p> <p>A: Yes, there is yes.</p> <p>Q: Something that just came into my mind was, who decides, you said about what's appropriate and what's not, and I wondered who decides that? I don't know, it just popped into my head.</p> <p>A: Yes, what's appropriate as regards the boundaries for what?</p> <p>Q: I suppose all of the boundaries.</p> <p>A: All of the boundaries?</p> <p>Q: Sort of in relationships with the service users, who decides what's appropriate and who decides about times and the doors?</p> <p>A: I mean the times and doors have been set by managers, things like that are just passed down to us and then we adhere to them. I mean and at times there is also, they ask for feedback from us, so we'd get some input as well. But usually it's the</p>	<p>Managers setting boundaries around doors/times Adhering to boundaries set by managers but giving feedback to managers Managers deciding</p> <p>Personal boundaries – closeness depending on person Boundaries differing person to person</p>	<p>Being influenced by management Adhering to professional boundaries Influencing management</p> <p>Personal boundaries are up to the individual nurse</p> <p>Having different views to others</p> <p>Physical relationship differing from nurse to nurse</p> <p>Providing physical comfort</p>
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<p>managers who decide most of those things. On the ward, let me think, now then most boundaries are set by the managers, but personal boundaries, as to what you would feel comfortable with and as to how close you might want to get to a certain patient, I think that is just up to the individual person, yes, which differs from person to person.</p> <p>I mean some people just do not want any contact at all, you know, not even to hold a hand or anything like that but, I mean that's something that I don't mind. If people want to be comforted then, you know, I don't mind comforting people. But again, there are boundaries and there are certain places you wouldn't do it and would do it. And certain people I perhaps wouldn't be so easy doing it, with a male. With a female it would be OK but perhaps not to, so much to hug a male.</p> <p>Q: What do you think influences your decisions about that, about how to be with different patients and service users?</p> <p>A: I think knowledge of the patient basically and just my experience as well. I mean I've worked at Millbrook now for nearly twenty years, so I've met a lot of people. I mean a lot of the patients, they're patients that we've known, that I have</p>	<p>Not minding when patients do not want physical contact with staff</p> <p>Feeling okay to comfort patients Boundaries around where it is ok and not to hug a patient</p> <p>Not hugging certain patients – males</p> <p>Knowledge about patients influencing decisions about boundaries</p> <p>Knowing patients over time (20 yrs) Feeling more comfortable with patients known longer Getting to know patients/safety risks</p>	<p>Tailoring the boundaries to the situation/setting</p> <p>Diversity influencing boundaries</p> <p>Being influenced by knowledge of the SU Being influenced by experience</p> <p>Being influenced by experiences of SU</p> <p>Needing to risk assess</p>
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<p>known for nearly all these twenty years. So with those people, I do feel a lot more comfortable than say somebody who's just come in, and then you get to know them and get to know their needs, I suppose, or if there's any risks or safety issues involved.</p> <p>Q: So do you think there's anything else? So it sounds like there's something about your own experiences, getting to know the patient, something about risk.</p> <p>A: Yes, I mean you've always got to assess risks anyway with people. As I say, just knowing that person and knowing what is safe and what isn't safe. Even when we're looking at the patient's own boundaries, they do change over their admission. So when a person comes in, they are always put on ten minute intermittent observations, which means we have to check where they are every ten minutes. So they're not allowed off the ward on their own, they have to have a member of staff with them.</p> <p>So after twenty four hours on a first assessment, we get a feel for that patient, know what the risks are, then we can look at reviewing those observations. They could go to, what we'd do next, would possibly be a general escorted, if we didn't know the</p>	<p>Having to assess risks</p> <p>Knowing what is safe or not with a patient Patients boundaries changing over admission Initially 10 min obs for all – not being allowed off ward without staff</p> <p>Getting to know the patient and risks in 24 hrs Reviewing obs after 24 hrs Moving to general obs if patient not known well</p> <p>Still being restricted to go off the wards</p> <p>Moving to more freedom depending on section</p> <p>Patients having to tell staff where they're going</p>	<p>Getting to know the SU and being influenced by risk and safety</p> <p>Being influenced by Sus risks</p> <p>Relaxing boundaries gradually depending on the risk</p> <p>Working within the legal boundaries</p>
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<p>patient really well, which means we wouldn't have to check on them every ten minutes, we'd just need to be aware of where they were on the ward. But there would be the restriction still of, they'd need a member of staff to go off the ward. If that worked OK and we thought there was no risk, we'd move them to either general, where they could go off the ward on their own, still with boundaries in place, depending on whether they're on a section or not, or we'd put them on a fifteen care plan, which means they could go off the ward just for fifteen minutes. But always we need them to tell us where they're going.</p> <p>Q: You said something about sections?</p> <p>A: Sections, yes. I mean they have boundaries in themselves.</p> <p>Q: Yes that's what, I hadn't thought of section and actually someone's liberty is taken away.</p> <p>A: Yes.</p> <p>Q: Do you think, do you think that gets in the way of the relationship you have with a service user?</p>	<p>Removing someone's liberty</p> <p>Still having a good relationship despite boundaries</p> <p>Thinking that patients understand that nurses not responsible for sections/boundaries Patients blaming drs, sw and families, not nurses</p> <p>Nurses helping patients to understand the section</p>	<p>Working within the legal boundaries</p> <p>Boundaries not an object to building relationship</p> <p>Not being blamed by Sus for the boundaries</p> <p>Explaining the boundaries</p>
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<p>A: Not generally no, it doesn't no, no it doesn't. We still seem to have a good relationship with them, yes. They seem to understand that, at the end of the day, the nursing staff are not responsible for them being in hospital or for them having been put on a section. That it's the doctors and social workers, even they blame their families, but they don't usually blame us for that.</p> <p>Q: Yes, that's good.</p> <p>A: But I mean I suppose because we just give them encouragement to appeal against the section. We help them to understand the section.</p> <p>Q: Yes, it sounds like you're offering more of the care, rather than the sort of</p> <p>A: The actual</p> <p>Q: Physical, I don't know, something about the legal, knowing the background?</p> <p>A: Yes, all the legal things, that's it yes. Like a detention in hospital, we're not responsible for that. We're just there to look after them whilst they're here.</p> <p>Q: And you said something as well about patient's boundaries changing over</p>	<p>Not being responsible for detention, being responsible for care</p> <p>Patients boundaries changing as become more relaxed Becoming more comfortable approaching staff Spending a lot of time together, getting to know them Patients discussing social lives/futures</p>	<p>Enforcers vs care givers</p> <p>Sus boundaries changing over time of admission</p> <p>Getting to know Sus socially</p> <p>Working towards recovery</p>
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<p>time. It sounds like the boundaries of leave change gradually, how do the service user's boundaries change, like their own personal boundaries, do you think? I wonder if they sort of change as their admission goes on and their perceptions?</p> <p>A: I mean they do because they, once, they become more relaxed here usually. So they feel more comfortable here, they become more relaxed about approaching staff. I mean we spend a lot of time with them, so we get to know them quite well in a social way. I mean they do discuss a lot of their social life with us, their dreams and desires, if you like, you know, what they want for the future. And we encourage that as well, you know, because that is always part of the recovery, to be discussing what the next move is for them, what they want to do next and moving on. So we encourage all that.</p> <p>But yes, I mean as they get to know us, they do become more relaxed with us. And the boundaries, their boundaries towards us drop as well I think, maybe come a little bit more, I mean I'm not saying everybody would, but I'm saying on the whole they would be able to talk to us a bit easier and discuss things and know they can trust us.</p>	<p>Encouraging talking about the future for recovery</p> <p>Patients becoming more relaxed as get to know staff Patient's boundaries lessening towards staff</p> <p>Patients knowing they can trust staff</p> <p>Hospital boundaries remaining the same, personal boundaries changing</p> <p>Some things set in stone</p>	<p>Sus relaxing their boundaries as get to know staff</p> <p>Personal boundaries changing</p> <p>Adhering to professional boundaries</p> <p>Boundaries as providing structure and predictability</p>
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<p>improved patient care as a whole, you know, for everybody.</p> <p>Q: Do you think then that the boundaries are important for a recovery?</p> <p>A: Definitely.</p> <p>Q: Those boundaries and structures?</p> <p>A: Yes, they are definitely.</p> <p>Q: How do you think they relate, I guess, putting the boundaries in and somebody's recovery?</p> <p>A: Again, it's like with the people going to bed at night, that is helping their recovery, because if they had the reverse sleep pattern, when they get home that's going to be a problem for them. So if we can get somebody having a good night's sleep, up in the day, then that is going to help the recovery. So we've got that boundary, they're not sat up all night drinking coffee and smoking, it's good for their health as well. And overall, it just gets people into a normal way of life I suppose.</p> <p>Q: It's like almost preparing them for</p> <p>A: Yes, for discharge.</p>	<p>Boundaries around night time</p> <p>Getting people into a normal way of life</p> <p>Preparing people for returning to society</p> <p>Needing to assess patients and being in bed preventing this</p> <p>Not seeing drs, activities, not having structure</p> <p>Needing structure for recovery</p> <p>Being personal depending on the patient</p> <p>Offering encouragement</p>	<p>Boundaries as providing structure and predictability for recovery</p> <p>Tailoring personal boundaries to the Sus</p> <p>Connecting as a person</p>
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<p>Q: Back into society?</p> <p>A: Yes and again, if they're in bed all day, they're not, we're not able to assess them properly. They're not seeing the doctors, they're not doing activities with the OT, and I think they need all those structures, if you like as well, to enable them to recover, where at night, they're just doing nothing.</p> <p>Q: I'm just thinking about the personal relationship again, I'm just wondering how you think your personal relationship with the service user helps in recovering really, that sort of personal relationship?</p> <p>A: I suppose, again, depending on the patient as to how personal you can be with a certain person, I mean some more than others. Just giving them encouragement, you know, discussing what their hopes and dreams are, all that sort of thing. But just talking to them as a human being, as one person to another, not as a member of staff, you're speaking to them more on, what we say is we develop a therapeutic relationship. I mean in some, that way you're coming across as a friend, but a friend, not a personal friend, do you know what I mean? Not a friend as in you would have and go</p>	<p>Talking as a human, not as a member of staff</p> <p>Developing the therapeutic relationship – coming across as a friend</p> <p>Being a type of friend, trusting and someone to turn to, not to go home with!</p> <p>Relationship depending on the type of patient</p> <p>Being able to give more to some patients than others</p> <p>Offering a hug to elderly patients being worth a thousand words to them</p>	<p>Developing the therapeutic relationship</p> <p>Being a type of friend</p> <p>Personal boundaries tailored to the SU</p> <p>The importance of the therapeutic relationship for recovery</p> <p>The physical relationship</p>
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<p>out with them and be at home and things like that. But they can look on you as a type of friend, as someone they can trust, someone they can turn to.</p> <p>So, as I say, and again it would depend again on the type, on the patient, as to how far you would go with that relationship.</p> <p>Q: That sounds really important for recovery?</p> <p>A: Yes.</p> <p>Q: And you said that hope?</p> <p>A: Yes, as I say, some people you can give more than you would to others, you know what I mean? Even could go up and meet people that we know for years and years, some of the more elderly patients, you go up and give them a hug and that's, that's worth a thousand words to some of them, just to have somebody give them a hug, you know.</p> <p>Q: It sounds like some people don't have that, this coming in here is their experience of other humans I suppose, and the care?</p> <p>A: Yes. I mean some don't want that or need it. They don't want that therapeutic</p>	<p>Some patients not wanting the therapeutic relationship</p> <p>Some patients distancing themselves</p> <p>Some patients needing the relationship</p> <p>Difficult to break the bond with some patients if over familiar</p> <p>Harder for the patient to break the bond</p> <p>Patients developing a close relationship with staff over time</p> <p>Having banter with patients</p>	<p>Adapting the therapeutic relationship to the person</p> <p>Balancing the relationship (not being over familiar vs being human)</p> <p>Breaking the therapeutic bond</p> <p>Developing a close therapeutic relationship with the SU over time</p>
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<p>relationship. They put themselves at a distance from you, some of the patients. But others, they sometimes need it. It can sometimes be a bit hard to break when they leave as well though I've found, if you've become a bit too over familiar with patients, you know, it can be hard to break that bond if you like.</p> <p>Q: Is it hard for both of you do you think?</p> <p>A: No, mostly I think it's harder for the patient, yes.</p> <p>Q: How do you manage that when it happens?</p> <p>A: Breaking what the bond or you become over familiar?</p> <p>Q: Yes and stepping back? It sounds quite, quite distressing actually.</p> <p>A: Yes. When we have people in here that have been in, they're in hospital perhaps six months to a year, and you can understand that over that time they do develop that, quite a close relationship with staff, you know. You have a lot of banter with them, you know, about life. I mean and to some extent they know about you as well. But I think we are always under the</p>	<p>Patients knowing staff</p> <p>Recognising how far to take the relationship Difficult to keep the patient at arms-length, not feeling as if you are pushing them away Not letting the patient feel they are being pushed away</p> <p>Balancing being friendly with being over familiar – not giving too much</p> <p>Balancing</p> <p>Patients thinking staff really care</p> <p>Caring in a different way, not doing anything for them, drawing lines without seemingly pushing the person away</p> <p>One or two patients that get too close</p>	<p>Maintaining the professional relationship</p> <p>Maintaining a balance between friendliness and professionalism</p> <p>Caring in a different way</p> <p>SU experiences impacting on the relationship</p>
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<p>understanding that this is a patient, they are going to go home, so we have to be very careful how far we do take that relationship. We just try hard to keep, it is hard though sometimes, to keep them at arm's bay, without you feeling that you're pushing them away. And you don't want to give them that feeling as well.</p> <p>So you're sort of being friendly, sociable with them, without being too over familiar, you know, giving your all, if you want.</p> <p>Q: Yes, it sounds like a balancing act?</p> <p>A: It is yes, definitely.</p> <p>Q: Not pushing but</p> <p>A: Yes it is, you've got to, they might think that, and it's hard again, they think that you are perhaps, you really care. I mean we do care about our patients but in a different way that we care about them and that we'll do anything for them. We don't to that extent, you know, we do draw lines, without it seeming that we're being harsh or pushing a person away. It is very hard.</p> <p>I mean again, it's not with everybody, it can be just the odd one here and there that gets</p>	<p>Needing a closer relationship- not having good relationships in the past Offering a different relationships to past ones but patients thinking it's more</p> <p>Finding it hard to draw the line (nurse)</p> <p>The relationship suffering when drawing a line (for patient) Patient seeing staff as family</p> <p>Family being there then suddenly not Staff being able to carry on – seeing the relationship as part of a job.</p>	<p>Finding it hard to draw the line</p> <p>Boundaries impacting on the therapeutic relationship (for the SU)</p>
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<p>this close. They seem to, they need that kind of relationships, you know, they've perhaps not had a very good relationship at home or in the past. And then they come in here and we're all very caring and give them lots of reassurances. We're just talking to them, you know, but they can sometimes think that it's a little bit more. And it's just hard, as I say, to draw that line. That is one of the hardest things to do I think.</p> <p>Q: Do you think when you have to draw that line and say, no it's time to go home now, does the relationship, what happens to that relationship, does it suffer do you think?</p> <p>A: I think it does for the person who's being discharged yes. I think that they do, they find it hard, that perhaps for this six/nine months they've had this family around them. And that's how they do see you I think. They've had this family around and then suddenly, there's nobody. And I think that's hard for them. I mean for us we just carry on, it's just, as I say, part of our job. It can be difficult for them, I do believe, yes.</p> <p>Q: OK, lots to think about there. So I'll ask you the next question but I think we've covered it really. Are boundaries within the</p>	<p>Boundaries for safety and security and to prevent coming overinvolved</p> <p>Not thinking about boundaries at work. Boundaries just being there Being used to boundaries</p> <p>Doing boundaries automatically Maintaining safety for staff and patients</p>	<p>Purpose of boundaries (to provide safety) Boundaries as providing structure and predictability</p> <p>Boundaries to maintain the professional relationship</p> <p>Boundaries as automatic</p> <p>Purpose of boundaries (maintaining safety)</p> <p>Constantly reviewing boundaries</p>
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<p>ward environment, and within relationships with service users, important and why?</p> <p>A: Yes, I think we did more or less answer it, didn't we? Yes they are important and I think there always has to be a boundary between staff and patients, don't there?</p> <p>Q: I think you said about safety and security?</p> <p>A: Yes, safety, security, all that yes, and becoming too over involved I think.</p> <p>Q: What different types of boundaries do you think about at work?</p> <p>A: Sometimes I don't think we think about them really. They're just there aren't they? We're used to them and so it's not something that we would possibly think, oh this is a boundary, I'm not going to move over that. But</p> <p>Q: It sounds like it's become almost</p> <p>A: It does become</p> <p>Q: Automatic</p>	<p>Reviewing obs boundaries every shift</p> <p>Reviewing personal boundaries</p> <p>Patients becoming attached to the staff team as a whole and needing them</p> <p>Discussing boundaries with the staff team/patients being attached</p> <p>Discussing whether things should be changed with a patient with the staff team</p> <p>Constantly assessing patients</p>	<p>Sus attaching to the team as a whole</p> <p>Talking to colleagues about relationships with SUs</p> <p>Assessing Sus constantly</p>
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<p>A: Yes it is, it's just, we just do it, don't we? We know, I suppose the biggest one again, is maintaining safety, looking at risks, I mean it's safety for staff and patients, that's always a big thing that is. We look at boundaries for the observations, they're looked at every day, because we look at them and see if we can review them every day, every shift. We can look at reviewing those, reviewing personal relationships, again.</p> <p>I mean we often, a lot of the time, if we do have a particular patient who does become attached to staff, it's not just one member of staff, it can be staff as a whole you see, that they become attached to and need. So we do talk about that as well at work, so that's something we do think about, because it's something we've discussed. So we think about, what are we doing with this person, what should we be doing, how can we change things?</p> <p>Q: Do you think about boundaries, in terms of treatment I guess, and viewing that relationship you have, as a therapeutic treatment?</p> <p>A: Yes, as in treatment as in just talking to somebody or assessing?</p>	<p>Observing patients to assess them</p> <p>Allowing patients to get on on the ward without interfering</p> <p>Patients having boundaries from staff too – getting on</p> <p>Maintaining staff physical safety</p> <p>Assessing what physical help a physically unwell patient needs</p> <p>Giving assistance in an appropriate manner</p>	<p>Maintaining own personal boundaries and respecting the SUs</p> <p>Purpose of boundaries (to maintain safety)</p> <p>Tailoring the boundaries to the SU</p> <p>The physical relationship</p> <p>Dignity and privacy influencing boundaries</p> <p>Diversity influencing boundaries</p>
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<p>Q: Yes, that's really interesting, something about crossing the physical boundary, when is that appropriate?</p> <p>A: Yes, just making sure that, you know, that when we have physical interventions they're done in a room with the privacy, you know. That they're females where, as possible, if it's a female we're dealing with, or males when it's a male. So looking at those kinds of things to, you know, for patients as well.</p> <p>Q: I think we've answered a lot of these.</p> <p>A: I think you do find, don't you, that a lot overlaps?</p> <p>Q: It does, definitely. How do you think boundaries develop, so how do you think your ideas about boundaries develop? You can think as far back as you want.</p> <p>A: Again, it comes from experience I think. I mean, like I say, if you want to think way back, it comes from when you're a child, doesn't it? There's boundaries in place for children, what's safe for them, what isn't. What you should do and what you shouldn't do, who you should speak to, who you shouldn't speak to. So there's always boundaries in place.</p>	<p>Considering risks</p> <p>Management influencing boundaries Boundaries being influenced by management Discussing problems with boundaries with other staff members in handovers</p> <p>Making other staff members aware of problems</p> <p>Making staff aware of infectious diseases and being able to discuss boundaries together</p> <p>Ward managers feeding back to higher management and</p>	<p>Being influenced by management</p> <p>Discussing boundaries with other staff members</p> <p>Influencing managers</p>
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<p>So we get, yes I think it's instilled in you from quite a young age. And as you grow older, those boundaries do change. Working in this environment, the boundaries have changed. Personally, I mean you have to be aware of the patients, again of risks and safety for everybody. You're looking at your risk, you're looking at the patients risks.</p> <p>Q: Do you think sort of, it sounds like other, I'm wondering if other people influence your boundaries, in terms of other staff or management?</p> <p>A: Yes, the management always do yes. They're always, I mean the smoking things, all those kind of things, are put in, the boundaries are put in by management. We, again, we have handovers and we discuss in handovers the patients. And again, if there's any problems with the boundaries, regarding this patient, we'd be discussing it as a team in the handovers. So we are all aware, you know, if this patient, the staff become aware, oh you've got to be careful because of such and such and with this.</p> <p>So in case they've got any infectious diseases or anything like that. So we are made aware of that and then we know what</p>	<p>thinking about changing boundaries</p> <p>Boundaries changing from bottom up Seeing problems more on the wards than management in the office Management making the final decisions</p> <p>Bottom up then top down</p>	<p>Being influenced by management</p>
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<p>boundaries to put in place, and we discuss them all together.</p> <p>Q: Where do you think, just again thinking, managers get their sort of ideas about boundaries and when to change the boundaries on wards?</p> <p>A: I suppose, I mean we get the managers on the wards and they'll go to meetings with the managers. So they'll be feedback from, I mean it could be feedback from us that the managers take to a manager's meeting and saying, this isn't working, what else could we try, can we do this, can we do that, and then it's OK'd.</p> <p>Q: So it sounds like it comes almost bottom up?</p> <p>A: I suppose that's really how it's got to come, hasn't it? Because as us working on the wards, we see the problems better than people who are sat in an office somewhere else. But they make the final decisions as to what can be put in place. And a lot of the times, I mean sometimes it doesn't have to go all the way to the managers but sometimes it does.</p> <p>Q: It sounds like it goes up and then back down again almost?</p>		
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<p>A: Yes, this is what we feel, take it away with you. Three months later</p> <p>Q: It comes, yes.</p> <p>A: It comes back.</p> <p>Q: The time boundary.</p> <p>A: Yes.</p> <p>Q: OK, I think that's probably everything I wanted to ask. Is there anything else that you think I've missed or anything that you think?</p> <p>A: No, I don't think so, no.</p> <p>Q: Anything you want to add?</p> <p>A: No.</p> <p>Q: OK, well thank you very much.</p> <p>A: That's OK.</p>		
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DCLINPSY RESEARCH PROPOSAL

17.09.2012 (version 2)

Candidate / Chief Researcher: Amy Richardson, Trainee Clinical Psychologist

Research Supervisor: Anna Tickle, Clinical Psychologist

**Title: Nurses' Perceptions of Relationship Boundaries with
Service Users in Acute Psychiatric Settings: A Grounded
Theory Study**

SYNOPSIS

Title	Nurses' perceptions of relationship boundaries in acute settings: a grounded theory study.
Chief researcher	Amy Richardson, Trainee Clinical Psychologist
Study aim	To explore nurses' perceptions of making, maintaining, as well as dilemmas in relation to maintaining relationship boundaries within acute inpatient settings, using a grounded theory approach.
Methodology	Semi structured interviews will be conducted with Registered Mental Health Nurses (RMNs) working with acute inpatient units. Semi structured interviews will be audio recorded for later transcription.
Number of participants	Between 15 and 20 participants will be interviewed.
Eligibility criteria	Registered Mental Health Nurses (RMNs) can participate in the study if: <ul style="list-style-type: none"> • they are registered to work as mental health nurses with the Nursing and Midwifery Council (NMC) • they currently work with service users within an acute inpatient psychiatric ward • they are willing to respond to open-ended questions about their experiences of boundaries within relationships with service users whilst inpatients on an acute psychiatric unit • they give consent to take part in an audio-recorded interview.
Intervention	Participants are expected to attend a one-off semi structured interview lasting approximately 60 minutes.
Analysis	A grounded theory analysis will be carried out in order to identify, analyse and report patterns within the data, which contribute to a grounded theory of important factors that contribute to nurses' perceptions of boundaries. This will follow the procedure outlined by Charmaz (2006).
Duration of study	This study is expected to last one year in total and will be submitted in partial fulfilment of the requirements for the Trent Doctorate in Clinical Psychology (DClinPsy) in September 2013.

STUDY BACKGROUND AND RATIONALE

Acute inpatient wards are a key component of mental health care in the UK, with two thirds of available resources from the National Health Service (NHS) mental health budget going to support acute inpatient services (Baguley, Alexander, Middleton and Hope, 2007). As mental health services have moved to more community based treatment, and there has been a decrease in the number of beds available, the threshold for admission has risen dramatically and there is little time for therapeutic interventions (Baguley et al., 2007). Indeed as Baguley et al. (2007) report, there are growing tensions between aligning inpatient care with current innovations in mental health care.

Many studies have revealed that service users are unhappy with the quality of care in acute psychiatric units, and state that there needs to be a shift in the way that professionals work if the needs of service users are to be met. For instance, Mind (2004), found that service users wanted staff to work in a collaborative way, to be flexible, to treat them with respect and value them as individuals. Similarly, in a qualitative study by Borg and Kristiansen (2004), it was found that service users value professionals who convey hope, share power, are available when needed, are open minded in trying new things that might help, and are willing to stretch the boundaries of what is considered to be a professional role.

However, there seems to be a mismatch between what service users report as being useful to their recovery, and the current experiences of service users who are inpatients in acute psychiatric units. As Borg and Kristiansen (2004) and Davidson (2003) outline, inpatient services have traditionally been seen as paternalistic, with the view that professionals effect change through the use of medication and treatment programs. Williams and Cormac (2007) further state that acute units are focussed on risk management and treatment rather than recovery, and Vassilev and Pilgrim (2007) suggest that perhaps acute units are more to do with social control than recovery. Gomm (1996) and Hall (2004) also state that control is exercised by professionals over the behaviours that are deemed socially inappropriate.

Borg and Kristiansen (2004), as well as other literature from service user movements, show that it is the treatment relationships that are key in bringing about recovery.

These relationships should be with someone who can share power to create an atmosphere of trust, and will leave the professional role and do something unexpected (Borg and Kristiansen, 2004). Gilbert, Rose and Slade (2008) also report that relationships are at the core of the service user experience, and consist of effective communications, cultural sensitivity and an absence of coercion. The professional is thus attributed with a sense of trust and as someone who has helped the service user to experience the acute psychiatric unit as a safe place. This highlights the importance of the therapeutic relationship in providing a safe and therapeutic milieu for people in acute inpatient units (Gilbert et al., 2008).

However, as Williams and Cormac (2007) report, the sorts of relationships that service users report as therapeutic may involve some aspect of professionals relinquishing responsibility that is, positive risk taking by handing responsibility over to service users. However, they further that professionals may find this difficult as they worry they may be blamed if the service user were to come to harm. Indeed, Tee, Lathlean, Herbert, Coldham, East and Johnson (2007) report that what is needed is for professionals, including nurses, to spend time with service users, to share decision making. However, this may imply being flexible with rules and boundaries by perhaps allowing service users to have a choice in terms of treatment and by doing less for them. Baguley et al. (2007) hypothesize that what maybe preventing a relaxation of boundaries is a fear of being blamed if the service user, or others, are harmed, and so they can find it hard to take positive risks. As Baguley et al. (2007) further state, professionals here have dual roles as custodians, which complicates matters. They believe that service users should receive care and therapy from the most appropriate professional, based on their ability to engage with the person, and that this may involve a blurring of professional boundaries (Baguley et al., 2007).

This difficulty of dual roles of nurses, in which they are carers and custodians is also expressed by Gilbert et al. (2008) and Goodwin, Holmes, Newnes and Waltho (1999). Indeed, Goodwin et al. (1999) suggest that perhaps there are too many roles for nurses in terms of being both carers and custodians, and there are not clear boundaries between the roles. They suggest that this may result in service users feeling unsafe within relationships.

Boundaries are one important aspect of relationships and are defined as the relational space created where service users and nurses can explore treatment issues within the safety of the therapeutic relationship (Schafer and Peternelj – Taylor, 2003). However, as already acknowledged, maintaining boundaries can be difficult in inpatient settings as nurses have dual obligations, including the power to deny service users freedom. Boundary maintenance is central to the therapeutic relationship, which can be confusing as the nurse has multiple roles. In a study by Schafer and Peternelj – Taylor (2003), it was found that service users valued nurses who focused on the therapeutic relationship and maintained firm boundaries.

As Mullen (2009) writes, a conflict has been highlighted between the sorts of relationships service users find helpful and healing, and the sorts of relationships that can be provided in acute psychiatric units. He furthers that the ideas being spoken about by service users are being eroded, as the focus of care is on containment of those considered to be at high risk of harm. He believes the care provided on acute units is currently too custodial and operates within an observational framework, which sets boundaries on difficult behaviour. However, as Hurley (2009) acknowledges, the values, attitudes and behaviours of nurses are being influenced by policies that seek to improve the service user experience, such as The Ten Shared Capabilities (Sainsbury Centre for Mental Health, 2004). Therefore, nurses are in a unique position to influence interactions in acute psychiatric units.

Although there has been a considerable amount of research about what is useful to service users and what 'recovery relationships' with nurses should look like (see for instance Slade, 2009), there has been no direct research with nurses about what impacts on their ability to form and maintain relationships with service users. As outlined here, forming relationships may be particularly difficult in this setting, especially as nurses have dual roles. Hem, Heggen and Ruyter (2008) expand that the environment is difficult, with involuntary treatment, unbalanced power structures and medication usage, and Hansen (1998) believes that mutual distrust operates. Boundaries may be a particularly difficult issue to contend with. Literature from the service user movement has outlined the need for nurses to be relaxed with boundaries in relationships, but the question remains as to how possible this is for nurses when they are not only carers, but also custodians.

Schafer and Peternelj-Taylor, (2003) surmise that impact of isolation of the work, the environment and the length and intensity of the relationship, as well as the service user's vulnerability need to be considered when creating, maintaining and evaluating boundaries in the therapeutic relationship. They further that different clients need different things, for instance adherence to rules and guidelines can provide a sense of security for some but for others this approach can seem restrictive and suffocating. However, as they assert, there are few studies that ask the question about how nurses are currently managing boundaries within relationships. They believe that more studies are needed on therapeutic boundaries as currently nurses are learning through trial and error.

This study is needed as no studies have explored the important factors that contribute staff perceptions of relationships with service users, specifically boundaries. Nurses are a particularly important staff group as they carry out the majority of therapeutic activity, including forming and maintaining therapeutic relationships, which as noted here has important therapeutic value. The environment of the acute psychiatric inpatient unit is particularly worth exploring in regards to this, given firstly the importance of them within mental health services, and also the unique role they play in terms of being therapeutic environments but also where service users may be held against their will.

As there has been little research in this area, a qualitative study is indicated in order to gain an in-depth understanding of nurses' perceptions of boundaries, and what important factors they consider when forming and managing boundaries. This will be useful for clinical practice as it is hoped this may help to improve understanding of relationships between nurses and service users through education and training. Service user literature indicates the importance of relationships in recovery (see for instance Slade, 2009). Ultimately, if relationships can be understood and therefore improved for service users within this setting, it may result in better experiences for service users in terms of overall emotional well being and quality of life whilst on acute units. More qualitative and quantitative research developed in the longer term may be indicated to see if an understanding of boundaries impacts significantly on nurses' practice and thus on the service user experience.

Acute psychiatric inpatient units are important areas for clinical psychology, where it is currently under-represented. The New Ways of Working Document for Applied Psychologists (British Psychological Society, 2007) outlines the role that Clinical Psychologists could play within the acute psychiatric setting, in terms of consulting to other professionals, such as nurses. Clinical Psychologists may therefore be in a position to explore and understand relationships within these settings, and disseminate and educate other professionals in order to improve the therapeutic relationships within this setting. By understanding existing environments, we may be able to help other professionals to better work within them, by applying our specialist knowledge of interpersonal psychology. Clinical Psychologists are also in a unique position to apply knowledge and to understand further the processes involved in building and maintaining relationships.

STUDY AIMS

The overall aim of this study is to explore Registered Mental Health Nurses' (RMNs) experiences and perceptions of making, maintaining, as well as dilemmas in relation to maintaining boundaries in relationships with service users who are inpatients on an acute psychiatric unit.

EPISTEMOLOGICAL POSITION

The lack of existing theory has led to the identification of grounded theory as the most appropriate form of methodology for this study. I have 'insider knowledge' and experience of the area of interest and so do not feel able to be distanced enough as required by traditional grounded theory approaches (Glaser and Strauss, 1967). Therefore, a social constructionist grounded theory approach seems to be most appropriate. Social constructionism can be defined as a theoretical perspective that people create social realities through individual and collective actions. Constructionists ask how something is accomplished within the world rather than seeing it as a given. They will therefore study people at a particular time and place and look at how they construct their views and actions (Charmaz, 2006). A social constructionist approach may be appropriate in this study because boundaries are something that have been constructed within a social setting. In addition, it can make use of my 'inside'

experience within the research, and emphasizes the co-construction of meaning between the participants and the researcher (McGeorge, 2011). Indeed, as Blumer (1979) writes, to be able to discover or generate questions, meanings and insights and theory, researchers need to be able to retain their knowledge and use their theoretical sensitivities. As Henwood and Pidgeon (2003) further add, theory does not emerge from or reflect the data, because interpretation and analysis is conducted within preexisting conceptual framework brought to the task by the researcher.

STUDY DESIGN

METHODOLOGY

Grounded theory methods consist of systematic yet flexible guidelines for analyzing qualitative data to construct theories grounded in the data themselves (Charmaz, 2006), rather than deducing testable hypotheses from existing theories (Glaser and Strauss, 1967), as is seen in more traditional positivist approaches.

Charmaz (2003) advocates the importance of going inside the studied phenomenon and gathering extensive, detailed descriptions about it whilst using grounded theory strategies to direct data collection. This is important because such data reveals participants' thoughts, feelings, intentions and actions as well as context and structure. Given the importance of gaining thick and detailed data, semi-structured interviews will be the data collection method for this study. This has been a useful data gathering method in various types of qualitative research, and is described by Lofland and Lofland (1995) as a directed conversation. The interviews in this instance will be semi-structured in that, as Charmaz (2003; 2006) explains, the researcher may have an idea of the area of interest and some broad, open ended questions to pursue, but there is also a wish to try and enter the psychological and social world of the participant.

NUMBER OF PARTICIPANTS

Between 15 and 20 RMNs will be recruited, based on the other grounded theory studies that have been published within the literature (for example Dilks, Tasker and Wren, 2010). This number also seems appropriate given the short time frame in which data collection and analysis are to take place. If anybody who initially expresses an

interest then withdraws, I will seek to recruit other RMNs. There are currently approximately 60 RMNs who are eligible to take part in this study.

SELECTION AND RECRUITMENT OF PARTICIPANTS

I will contact RMNs from Nottinghamshire Healthcare NHS Trust, working within the acute inpatient unit, the Millbrook Mental Health Unit, and invite them to take part in the study. I will contact them via my research supervisor, my field supervisor, Lisa Ball, and the Ward Managers. I will contact all RMNs on every ward (approximately 60 RMNs). I will contact RMNs by sending an invitation letter (appendix one) and a participant information sheet (appendix two). They will then be able to express their interest to me by returning a form in a stamp addressed envelope, or by emailing the researcher directly (appendix three). If no reply has been received after one month, a reminder will be sent.

If there are any difficulties in recruiting the required number of RMNs within the above acute psychiatric inpatient unit, I will contact the Nottingham City Acute Psychiatric Inpatient Unit using the same procedure.

INCLUSION AND EXCLUSION CRITERIA

Male or female RMNs can participate in the study if:

- they are registered to work as a Mental Health Nurse with Nursing and Midwifery Council
- they currently work in the NHS, within the Millbrook Mental Health Unit, and are working with service users who are inpatients within the wards on the unit
- they consent to taking part in an audio recorded interview.

PRACTICAL ASPECTS

Due to the shift patterns that RMNs are likely to work, I will be flexible in the timings that semi structured interviews will take place, for instance before or after an RMN's shift. Semi structured interviews will take place in a location considered familiar to, and convenient for the participants (ideally at their usual place of work if agreed, or a room can be booked at either the University of Nottingham or the University of Lincoln

depending on convenience for the participants). All interviews will be conducted in a private and easily accessible room.

Each semi structured interview will be audio-recorded for later transcription (which will be made clear on the participant information sheet, consent form (appendix four) and at the beginning of each interview). This will be done using a digital dictation device.

EXPECTED DURATION OF PARTICIPANT PARTICIPATION

Participants will attend a semi-structured interview which is expected to last approximately 60 minutes in duration.

INTERVIEW CONTENT

I will conduct the semi structured interviews myself. At the beginning of interview, I will introduce myself, review the purpose of the study, consent form and procedure. Certain items will then be discussed, including confidentiality. Confidentiality will only be breached by myself if there is concern about safeguarding children or adult issues. This will be outlined in the participant information sheet. Each participant will then sign the consent form before participating in the interview.

A semi-structured interview schedule has been designed specifically to capture the RMNs' subjective experiences of making, maintaining and dilemmas in relation to maintaining boundaries with service users (appendix seven). This has been designed based on previous evidence in the literature (see for instance Charmaz, 2006), and with discussion with my research supervisor. I intend to cover all topics during the interviews, however the schedule will be applied flexibly depending on the content of the discussion.

I will use an iterative process, adapting and modifying the interview schedule every two or three interviews based on the information I collect from participants. Each interview will be transcribed and analysed before the next takes place, in order to inform any changes in the interview schedule.

ANALYSIS

A grounded theory analysis will be carried out within a social constructionist framework. As outlined, grounded theory consists of systematic inductive guidelines for gathering, synthesising, analysing, and conceptualizing qualitative data to construct theory (Charmaz, 2001).

The grounded theory analysis procedure will follow that outlined by Charmaz (2003), which is shown below. However, in keeping with the principles of grounded theory, this will be applied flexibly and there will be movement back and forth throughout the phases.

- simultaneous involvement in the data collection and analysis phases of research
- developing analytic codes and categories from the data, not from preconceived hypotheses
- constructing middle-range theories, which can be used to explain specific behaviour and processes
- memo-writing, that is, analytic notes to explicate and fill out categories
- making comparisons between data and data, data and concept, concept and concept
- theoretical sampling, that is, sampling for theory construction to check and refine conceptual categories, not for the representativeness of a given population
- delaying the literature review until after forming the analysis. (p. 83).

Participants will not be asked to check or validate the data, however, my research supervisor will check my coding and concepts to make sure that I have not under-or over-represented aspects of the data. As Charmaz (2006) states, this will provide a degree of validity in terms of credibility for this study, as it is an important criteria for grounded theory studies.

SERVICE USER INVOLVEMENT

My research supervisor has reviewed the participant information sheets, and consent form. Any problems with readability or study design will also be addressed here.

EXPECTED DURATION OF THE STUDY

This study is expected to last one year in total (from September 2012) and will be submitted in partial fulfilment of the requirements for the Trent Doctorate in Clinical Psychology (DClinPsy) in 2013. The duration may be extended to September 2014 in order to publish or disseminate the findings.

PROPOSED TIMESCALE

Mar 2012	Submit research proposal (19 th Mar 2012)
Apr 2012 - Jun 2012	Receive feedback on research proposal Meet with Research Supervisor Make amendments to research proposal
Jun 2012 - Aug 2012	Obtain ethical approval (University of Lincoln and Research and Development department, Nottinghamshire Healthcare NHS Trust).
Sept 2012 – Jan 2013	Continue literature review Locate participants
Jan 2013 – June 2013	Arrange and conduct semi-structured interviews Audio tapes of interviews sent to a transcription service Interview schedule adapted accordingly Continue literature review
Mar 2013 – Sept 2013	Code and analyze data Prepare first draft of thesis Subsequent drafts
Sept 2013	Submit final thesis

SPECIAL EQUIPMENT

The semi-structured interviews will be recorded on a digital dictation device, which will be the only special equipment required for this study.

FUNDING/RESOURCES

This study will be funded partly by the University of Lincoln (£500), and outstanding costs funded by the researcher.

The estimated total cost of this research study is £818.11; a breakdown of this amount is shown below. Participants will not be paid to participate in this study.

Item	Cost	Supplier
1 x Digital Dictation Device	£34.99	Argos
1 x Pay as you go mobile phone (Samsung E1080i)	£9.97	Tesco Mobile
100 x 2 nd class C5 plain envelopes	£44.51	Royal Mail
Researcher's Travel (77.4miles x 15) at 24p/mile)	£278.64	n/a
Transcription Service (minutes at 0.50p/min)	£450	TBC

ETHICAL AND REGULATORY ASPECTS

ETHICAL COMMITTEE AND REGULATORY APPROVALS

The study will not be started before this protocol, consent forms, participant information sheets and proposed interview schedule have received approval from the University of Lincoln's Ethical Committee, and the relevant NHS Research & Development (R&D) department. Should amendments be made to the protocol, the changes in the protocol will not be carried out until the amendment and revised informed consent forms and participant information sheets have been reviewed and received approval from the University of Lincoln's Ethical Committee and NHS R&D departments. Minor protocol amendments only for instance for administrative changes may be implemented immediately and the University of Lincoln's Ethical Committee and NHS R&D departments will be informed.

The study will be conducted in accordance with the British Psychological Society's Code of Ethics and Conduct (2009) and The University of Lincoln's Ethical Guidelines.

INFORMED CONSENT AND PARTICIPANT INFORMATION

I will ensure there is a minimum of 24 hours between participants receiving the information sheet and giving consent on the day of the semi structured interviews. I will provide participants with the information sheets and take consent from the

participants. However, it is expected that the duration between these events will be greater, for example it is expected that the interviews will be arranged 2-4 weeks in advance of it taking place. This will help to ensure that participants have enough time to decide whether to take part in the study. It will be made clear on the participant information sheet that the decision regarding participation in the study is entirely voluntary.

The participant and I will both sign and date the consent form before they can participate in the study. The original copy of the signed and dated consent form will be retained in the study records, held in secure storage at the University of Lincoln. The participant will also receive a copy of the consent form for their own records.

PARTICIPANT WITHDRAWAL

Participants can withdraw from the research project, including from the semi-structured interview, at their request, up to 72 hours after the interview, and without penalty. Participants will be made aware of this via the participant information sheet and consent form. In this instance, participants can also request that any personally identifiable data, including recordings, be destroyed for up to 72 hours following the interview. This is considered to be sufficient time for participants to reflect on the interview and consider withdrawal. This can be done via contacting myself as researcher via the contact details stated on the participant information sheet.

After 72 hours, it will not be possible for participants to withdraw their data as it will have been transcribed and its removal will affect the analyses. Again, this will be made clear to participants via the participant information sheet and consent form.

I recognise that there may be a risk of participants disclosing instances when they may have broken, or are currently breaking, boundaries such that would violate a safeguarding adult or child issue. It will be made clear to participants that any disclosure of this kind will be discussed with third parties. It will also be made clear that participants can reserve the right not to answer a question without giving a reason, if they do not wish to discuss issues of this nature. In addition, participants can withdraw from the interview at any time and without penalty.

RISKS FOR RESEARCHER

It is not expected that there will be any risks for myself as the researcher. Semi structured interviews will be carried out in line with the University of Lincoln's Lone Working Policy. Support will be available from my research/field supervisors should this be required at any point during the study.

CONFIDENTIALITY

A transcription service will be used to transcribe the data. In this case, this individual transcriber will be required to sign a confidentiality agreement prior to this taking place (appendix five). This information will be made clear to participants on the participant information sheet and consent form.

In order to ensure that participants cannot be identified in any publications, pseudonyms will be used and any references to personal information will be changed. Participants will be given a unique identification number to ensure confidentiality.

DATA PROTECTION

In line with the Data Protection Act of 1998, all information and data will be kept confidential under safe storage at the University of Lincoln. Access to the information will be limited to myself as researcher, research tutors on the Trent DClinPsy programme and administration staff or the Trent DClinPsy programme at the University of Lincoln.

Identifiable data: This will be stored in a lockable filing cabinet at the University of Lincoln, and includes:

- signed consent forms
- a list of participant names and their unique participant identification numbers and pseudonyms (which will be assigned for use on transcripts, written notes and electronic documents).
- contact details of participants (telephone number, address or email address according to the participant's preferred method of contact)

Anonymised data: All anonymous data will be stored separately to the identifiable data in a lockable cabinet at the University of Lincoln, which consists of:

- transcriptions of semi-structured interviews
- written notes

The semi-structured interviews will be audio recorded using a digital dictation device for later transcription. Electronic files (including the audio recordings and electronic versions of the transcriptions) will be held on an encrypted data stick, and password protected to restrict access to authorised users only.

RECORD RETENTION AND ARCHIVING

In line with the Data Protection Act (1998), audio files, transcriptions and notes from interviews will be retained for at least 7 years at the University of Lincoln. Judith Tompkins will be the guardian for this data.

PUBLICATION AND DISSEMINATION

This research study will be submitted in partial fulfilment for the Trent Doctorate in Clinical Psychology (DClinPsy) in September 2013. I intend to submit the findings to a peer-reviewed journal to disseminate the findings. Pseudonyms will be used and any references to personally identifiable information changed to ensure participants cannot be identified in publications.

An information sheet summarising the main findings from the study will be offered to participants in 2013/14 following the final analyses. I will gain consent for this through the consent form, in which I will ask to hold participant's contact details on record to enable me to send out this information.

WORD COUNT: 4 673

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Appendix I: Interview Schedule 1 (First 5 interviews)

- What do you view as boundaries/how would you define them? Both within the ward environment and within relationships with service users.
- Have your views about boundaries changed over time? Again boundaries refer to both within the ward environment and within relationships with service users.
- Are boundaries within the ward environment and within relationships with service users important and why?
- What different types of boundaries do you think about at work?
- What do you view as the relationship between boundaries and promoting the recovery of service users?
- How do you think boundaries develop, within the ward environment, within relationships with service users? And within broader everyday life?

Appendix J: Interview Schedule 2 (Interviews 6-8)

- How would you define what boundaries are? Both within the ward environment and within relationships with service users.
- How do you think our ideas about boundaries develop/where do our ideas come from?
- What different types of boundaries do you think about at work?
- What do you view as the relationship between boundaries and the recovery of service users?
- How does implementing boundaries impact on your relationship with service users?
- What factors do you consider when implementing boundaries with service users?
- How do perceptions of risk/safety impact on implementing boundaries?

Appendix K: Interview Schedule 3 (Interviews 8-14)

- How would you define what boundaries are? Both within the ward environment and within relationships with service users.
- Where do your ideas about boundaries come from/how have they developed?
- What sorts of boundaries do you consider at work?
- What sorts of things do you consider when implementing boundaries with service users?
- How do perceptions of risk/safety impact on implementing boundaries with service users?
- How does implementing boundaries impact on your relationships with service users?
- What makes it difficult to maintain a boundary? What makes boundaries slip?
- What factors do you consider when relaxing boundaries? Has it ever been useful to relax a boundary?
- What do you view as the relationship between boundaries and recovery of service users?
- Do you think your colleagues share your views on boundaries?